Enhancing Community-Based Care in HKPR

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Enhancing Community-based care: Improving care accessibility and interagency communication efforts in the HKPR region.

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Abstract

Community-based care has proven to be an effective alternative to primary care, offering clients more personalized and timely services at conveniently situated locations. Nonetheless, identified gaps in accessibility and communication within current practices and services can significantly compromise client well-being. Through a comprehensive approach encompassing literature reviews, service model assessments, input from service providers via focus groups, and SWOT analyses, this study sought to address these shortcomings by formulating recommendations for improving interagency coordination and ensuring accessible care provision. From the research, it is clear that collaboration disparities and lack of accessibility contribute to negative client health outcomes and suboptimal care experiences by delaying care, not sharing pertinent information or preventing or deterring clients from seeking care in some capacity. By promoting group cohesion, exploring new technological platforms, enhancing training, acquiring funding and utilizing new and novel collaboration structures/resources and service models, the proposed recommendations have great potential to benefit the Haliburton-Kawartha-Pine Ridge (HKPR) region in providing a better quality of care and upholding Canadian legislative health standards.

Introduction

Community-based care can be defined as Coordinated, integrated, and alternative care provided in a range of community locations while placing strong emphasis on warm handoffs. It relies on the utilization of non-primary care and non-medical professionals in settings other than hospitals, doctor's offices, etc. Paramount to community-based care, is the effective communication and collaboration among service providers to facilitate the exchange of vital information, best practices, and services.

Moreover, an important aspect of community-based care is the notion of warm handoffs. This practice describes the delivery of care while exhibiting compassion and respect for patients and emphasizing effective reintegration into society. Warm handoffs ensure that client needs are met while making them feel comfortable, respected and prepared for life after or during treatments. Delivering the necessary care or treatment to an individual in the justice system in a kind, understanding and empathetic manner while providing them with the necessary resources to thrive in their community when they leave, is an example of how agencies could use ensure warm handoffs in their services. This aspect is particularly important for organizations like the

Human Services and Justice coordinating Committee (HSJCC), as community-based care seeks to cultivate an inclusive, non-judgmental environment for clients.

In the Canadian context, an average of only 15% of the population, 4.7 million people, report having comfortable access to care [1]. When put into the context of specific populations, the dire need for improvised healthcare and implementation of community-based care is clear. In Ontario, approximately 3.5 million people seek mental health care [2] however, 46.1% of people reported unmet needs in terms of mental health services [3]. More broadly, in Canada, 85% of the population, or twenty-seven million people, don't have access to a primary care facility [4]. These statistics demonstrate the current lack of healthcare accessibility in Canada and the urgent need for enhancements across the nation. According to the Canada Health Act, all Canadians have the right to reasonably accessible care, a right that is not being fully realized at present [5]. Therefore, this research holds significant importance as it strives to uphold the legislative mandate ensuring Canadians' reasonable access to equitable healthcare.

The overarching purpose of this project is to enhance communication of agencies and the quality of care provided to HSJCC clients by making it more accessible, timely, and tailored to their specific needs. It involved exploring various service model concepts, assessing the implementation of these models in different regions, and evaluating their success. This project further sought to investigate alternative methods for service providers to deliver care within community-based settings and to improve communication and coordination among these providers, ultimately facilitating seamless transitions of care for populations in need. The research is necessary for all communities locally, nationally, and internationally because each community has different sectors or populations of people that face unique barriers surrounding healthcare and mental health services. These barriers need to be addressed and mitigated so that all populations can have equal access to the care they need. This research on the challenges faced and how to implement community-based care solutions will help address these issues. Overall, this project provides recommendations, based on evaluations of service models and communication platforms, that aim to improve coordination and communication among service providers.

In addition, the recommendations will help bridge the gap regarding proper healthcare access in our current healthcare system by seeing what new community-based care methods can be implemented, and seeing how current methods can be improved. This also aligns with the

United Nations Sustainable Development Goals. Particularly goal number 3: is good health and well-being, because this project outlines the crucial need for sufficient access to all kinds of healthcare and with goals 10 and 11: reduced inequalities and sustainable cities/communities because it seeks to create more equitable health care and, in turn, create sustainable communities and decrease inequalities between populations [6].

Background

In an era defined by significant medical advances in the healthcare industry, the emerging concept of community-based care has been recognized in the provision of quality care services. As primary healthcare facilities are struggling with overwhelming amounts of patients and limited resources, community-based care practices can prove to be a beneficial alternative. Barriers, service models, current methods in place near the HKPR region, and improvements/evaluations of community-based care and communication aspects were explored to gain an understanding of the current state of practices and formulate improvements.

Improving accessibility of care for clients is a significant challenge in community-based care provision. To effectively address this issue and identify areas for improvement, it is crucial to have a comprehensive understanding of the available services available in the HKPR region, as well as the gaps that currently exist.

The Peterborough/ HKPR region offers a variety of community-based care services. Overall, the goals of these services include assisting with day-to-day living, helping to maintain independence, keeping members connected to the community, fostering good health and well-being, being affordable and accessible, and promoting peace of mind [7]. These services can be grouped into categories. Firstly, there is the provision of transportation services for community members who lack access to personal vehicles or public transportation. These services facilitate transportation to and from appointments, as well as assisting with essential chores like grocery shopping.

Other services provide well-being aid. For instance, Meals on Wheels is a program that provides seniors who cannot cook for themselves with 3 meals a day. Additional services include social events and dinner gatherings aimed at boosting community morale and nurturing mental health. Furthermore, exercise classes are offered to ensure that community members remain physically active and engaged in their well-being.

An intrinsic component of community-based care is providing care closer to where patients need it, so there are a variety of services that offer help at home. These include doing chores in one's home, workers providing friendly visits, and the medical equipment program in which trained professionals go to the homes of patients to assist with medical equipment needs. There are also two programs called "Home at Last" and "Home First" that both provide medically trained professionals who go to patients' homes to provide a wide array of medical care outside of a primary care facility [7].

While services in the HKPR region exhibit a certain degree of accessibility, notable gaps persist. Primarily, transportation remains limited to the Peterborough area, potentially hindering individuals in need of medical assistance outside this vicinity. Furthermore, the scope of home care services predominantly encompasses household tasks and basic medical care, overlooking various other forms of community-based care. Moreover, existing home care services primarily target elderly populations, overlooking the diverse needs of other demographic groups that could benefit from these services.

Since it has been established that there are gaps in existing services, it is important to evaluate how care is being provided in HKPR regions. Service models play a pivotal role in community-based care, offering structured delivery of care for individuals. Many different service models deliver community-based care, but generally, they can be divided into two categories: those that use medical professionals and non-medical professionals. Community-based care often emphasizes alternative forms of care, therefore many of the service models describe using non-medical professionals to deliver services. The evaluation of strengths and weaknesses of service models is important to this research because it can provide insight into which models would benefit the HKPR communities to provide more accessible care and fill the gaps left by services.

The concept of patient navigation is a major part of providing equitable and accessible healthcare, especially in modern society when health issues are diverse and complex. It intends to reduce barriers and bridge gaps in healthcare services [8]. Currently, the main access point for patient navigation is in primary care, which presents challenges due to the overwhelming demand in hospitals, making comprehensive care delivery more difficult to access for clients.

The implementation of community-based patient navigation systems is a novel concept that shows promise in providing adequate healthcare to the necessary populations. One service model that has proven to be useful in the delivery of community-based care is the Lay Person service model, which is defined as utilizing a mobile non-medical professional who is trained in a specific task [8]. This service model aims to remove barriers to facilitate easier access to healthcare by providing warm handoffs in central locations, such as one's home. In some instances, Lay persons can work with health professionals on a team. The training involved in Lay person models requires gaining knowledge of specific diseases, illnesses, or conditions to be able to work independently without a healthcare professional present. Patients' outcomes reported in Lay person-led patient navigation include improved general wellness, reduced financial stress and reduction in emergency room/hospital visits [8]. The task-shifting service model is very similar to the Lay Person service model and involves the utilization of community health workers as front-line care providers in replace of physicians or trained nurses [9]. Both of these service models are already used in HKPR communities to provide the services already discussed.

A novel service model that could enhance accessibility is the Balanced Care service model which represents an approach that emphasizes the equal availability of primary care and community-based care, ensuring that neither discipline is overwhelmed, and both can deliver optimal care [10]. While this model applies to all types of healthcare, it specifically focuses on mental healthcare. The article by Thornicroft and colleagues, states that one universal model of balanced care is not feasible because different countries experience different situations, rather the model must be tailored to address the unique needs of low-, middle-, and high-income countries [10]. In high-income countries like Canada, the balanced care model implements a series of specialized services to improve care and accessibility under the following categories: outpatient clinics, community mental health teams, acute in-patient care, long-term community-based residential care, and work and occupation. These services would target areas of poorly met needs identified in high-resource countries: primary care, general adult health, and specialized adult health services [10]. Overall, this model would facilitate better accessibility of community-based care by utilizing many different services involving both medical and non-medical professionals to provide services in timely matters and central locations.

Seeing as the HKPR region is ethnically diverse, providers need to exhibit cultural competency. When healthcare workers lack cultural knowledge, it can pose a significant barrier that creates an environment where individuals feel judged and stigmatized. This can make care feel inaccessible because clients won’t seek it out if they feel disrespected. To address this, the Culturally Competent Community Care model takes a systematic approach to reduce these barriers, improve access to healthcare, and promote equity from both individual-focused health to whole community population-focused health perspectives [11]. This model has four key characteristics of cultural competence: caring and cultural sensitivity, knowledge, and skills [11]. Successful implementation of this model relies upon the specific training of community workers in these key characteristics. A study conducted by [11] stated that the Culturally Competent Community Care model had positive effects on health outcomes, such as higher rates of immunization, reduced rates of morbidity and mortality, and an increase in migrants seeking healthcare, ultimately making it more accessible.

The novel concept of community-based forensic teams has been implemented in the United Kingdom and the United States in the last decade. These teams comprised of non-medical professionals, identify individuals who would benefit from exiting the justice system and receiving alternative care. Three service models have been useful in aiding the delivery and facilitating the accessibility of care from these community-based forensic teams: Parallel, Integrated, and Sequential Intercept service models. The Integrated service model describes using forensic specialists working within community mental health teams. Specialists using this model work on generic community mental health teams. The parallel service model describes using forensic specialists working on a separate health team. Specialists in this model carry out assessments and act as case managers [12].

The Sequential Intercept model provides evidence that a community-based care approach in the forensic justice system may be superior to conventional treatment approaches when addressing persons with mental health illnesses [13]. This model aims to reduce the punishment of persons with mental health and addiction issues by allowing intervention at any point in the criminal proceeding to redirect them somewhere more beneficial to their recovery and reintroduce them into society. This would be implemented by community mental health service providers who would be involved in cases and provide the necessary treatment, in addition to other community support services such as call centers, forensic officials trained in community-based services, etc. [13].

All three of these models have only been implemented and evaluated in communities outside of Canada, however, Mohan and Colleagues have laid out recommendations, such as measuring violence outcomes, that would help provide further evaluations. Since Canada is similar to these countries, these have the potential to be successful in the HKPR region. Overall, all of these models could improve accessibility to care as they are located in communities and facilitate warm handoffs because they help individuals reintegrate into society after incarceration with the services they provide and by teaching offenders life skills.

In contrast, medical service models are not as common in community-based care because there is less emphasis on alternative methods of care. One example of a medical service model is a Nurse-based Navigation model that describes using nurses to provide care. Medical service models are less popular in delivering community-based care because medical professionals' main focus is typically their primary care facilities and they do not always have the resources to deliver care outside of those facilities [8]. Therefore, these kinds of models are not likely to improve access to community-based services.

It has been demonstrated that different populations face common and unique barriers to care accessibility. These barriers not only inhibit individuals from obtaining the necessary care they require but also magnify the challenges faced by primary healthcare organizations. The resultant influx of emergency room admissions places stress on these facilities, depleting their resources and impeding their ability to deliver adequate care. Identifying these is very important because in doing so, service providers can come up with solutions to alleviate these barriers to make care more accessible for all clientele. In addition, in understanding the challenges these groups face, providers can better select delivery methods (service models) that would provide the best outcome.

One of the biggest client populations in the HKPR are those who struggle with mental health challenges. One in five Canadians experiences a mental illness in a given year [2], however, only 44% of these eight million people report receiving adequate care [14]. This means that approximately 4.5 million people in Canada face barriers that impede their access to mental healthcare. The main barrier faced by people seeking mental healthcare is the stigmatization of mental health illnesses that is prevalent among healthcare systems and providers [15]. This barrier can create consequences such as discontinuation of care, delay in seeking care, and suboptimal care provision. To reduce the stigma and mitigate this barrier, Canadian studies have identified "key ingredients" to help do this, such as teaching skills that enable facilitators to model person-first behaviours, interventions that include myth-busting and transformative learning, and emphasizing provider-involved roles [15]. To implement these changes, community-based workers need to be trained in low-intensity psychosocial support, establishing support groups, raising awareness about stigmatization, and supporting community-based rehabilitation [16]. For such training to be feasible, community-based mental healthcare should be offered in a variety of locations such as homes, schools, community centers, or online. The spectrum of services offered includes mental health awareness, psychoeducation, skills development, and treatment. The study conducted by Kohrt and colleagues, states that when healthcare workers are proficiently trained to combat the stigmatization of mental health, community-based care becomes a valuable alternative to conventional primary care facilities [16]. There is also evidence that community-based care can reduce hospitalizations, relieving the strain on primary care facilities and bridging the gap for those who have been deprived of the care they require [16]. It is clear that when community workers are trained in mitigating the barriers/stigma against mental healthcare, community-based care options can be an accessible alternative to lessen the stress on primary care facilities and aid in providing equitable care.

Since the HKPR region has many communities that lie outside of the main residential areas, the barriers that rural populations experience are important to investigate as well. The remote and isolated nature of these communities magnifies the obstacles they face, including limited access to healthcare facilities, scarce local resources, inadequate community support, and transportation limitations. When residents of rural communities do not seek the care they need, they rely on family as a “de facto support system” [17], which in turn causes the mental health of the family members to consequentially deteriorate. These issues can also be exacerbated depending on how rural/isolated the communities are. Due to the shortage of healthcare facilities in rural areas, residents often gravitate toward primary care facilities, even when alternative care options may be more suitable. The establishment of patient support groups is a form of community-based care that may help address this population. These groups create a local and easily accessible support system for patients. Implementing referral mechanisms to provide expert services directly within rural communities is a valuable approach to enable those who are reluctant to seek mental healthcare in larger cities due to fears of discrimination [18].

Overall, seeing as community-based care revolves around providing care to people when and where they need it, implementing these practices would be very beneficial to the rural population by expanding access to care, diversifying service options, and augmenting resources. This, in turn, contributes to the development of healthier and more resilient communities.

The HKPR region, particularly Peterborough is currently facing a homelessness crisis [19], therefore it is imperative that the challenges these individuals face be examined. The homeless populations in Canada are particularly susceptible to disease and illnesses due to their lack of access to basic necessities such as permanent housing, food, clean water, and more. This disproportionality of medical disease can lead to long-term illnesses and high mortality rates [20]. Despite their pressing need for healthcare, these populations face access barriers that can be insurmountable from societal factors like housing crises, criminalization, and stigmatization. A study conducted on the homeless population in Calgary, Alberta identifies three categories of barriers homeless people face: patient-level barriers, provider-level barriers, and systemic barriers [21]. Patient-level barriers can be further subdivided into two sub-categories: emotional barriers and patient knowledge and priority settings. Emotional barriers encompass the fear among homeless individuals of receiving bad medical news, which exacerbates their already stressful circumstances. The added stress can be overwhelming, especially when they lack a support system. Priority setting and lack of knowledge indicate that healthcare is often an afterthought to more immediate concerns, such as securing shelter for the night or finding their next meal. Moreover, many homeless individuals may not be aware of the locations of clinics or healthcare facilities. Provider-level barriers encompass environmental obstacles and discrimination. Environmental barriers include the inaccessibility of healthcare facility locations. Discrimination refers to the stigmatization of homeless people, causing healthcare workers to be less willing to serve this population due to misguided preconceived notions. Systemic barriers encompass more common and overarching challenges, such as financial barriers, lack of transportation and resources, and more [21]. All of these obstacles make care inaccessible to homeless individuals either by deterring them from seeking care due to various factors, making care facilities too far to travel to or making services unaffordable.

To address these barriers, a study introduced a conceptual framework for caring for homeless inpatients, known by the acronym A SAFE DC (Assessing housing status, Screening and prevention, Addressing primary care issues, Follow-up care, End-of-life discussions, Discharge instructions, Communication method after discharge). While this framework has yet to be evaluated, it is believed that implementing a “checklist” with the acronym A SAFE DC could enhance care for homeless populations [20]. Community-based facilities would also be beneficial to the homeless population because they would be in accessible locations, employ medical staff who are trained in de-stigmatization, provide information about primary care locations and services, and are open during more reasonable hours.

The number of elderly individuals with unmet care needs is increasing, therefore, to help address this issue, the specific barriers they face need to be examined [22]. Elderly populations often encounter challenges when acknowledging their need for assistance and seeking help, influenced by generational values and morals [23]. They are particularly at risk for health issues in general due to the natural challenges that come with aging. Moreover, they are at increased risk of developing mental health issues because, they may face the loss of loved ones, financial uncertainties related to retirement, physical ailments, and other significant life changes that can be challenging to adapt to.

Despite their heightened need for comprehensive care, the elderly face many barriers that prevent them from accessing this care. For example, in one study a participant stated that they did not feel comfortable in sharing their private life with a stranger, so they never sought out healthcare [23]. In addition, many people reported having the personal belief that "I should not need help", especially regarding mental healthcare. A unique barrier faced by the elderly is the limited availability of around-the-clock care, often due to affordability issues or lengthy waitlists [24]. These challenges are compounded by more general barriers such as cost and lack of transportation.

Community-based care facilities offer a potential solution by providing elderly individuals with a shared common space or support group. This would allow them to connect with peers who are navigating similar challenges in accessible facilities, to destigmatize the notion that they do not deserve assistance. Furthermore, locating these facilities in communities with a high concentration of elderly residents ensures greater accessibility and support.

Indigenous Peoples in Canada have confronted many historical and ongoing challenges, one of them being barriers surrounding accessible healthcare. These challenges faced by Indigenous Peoples can be divided into three categories: proximal, intermediate, and distal [25]. Proximal barriers encompass factors such as geographical isolation, limited access to education, and biases held by healthcare professionals that can result in inequitable care. Intermediate barriers include the lack of employment opportunities within Indigenous communities, income disparities, and the inaccessibility of healthcare systems in these communities. Distal barriers trace back to systemic issues rooted in colonialism, racism, and social exclusion, which have resulted in a limited Indigenous representation in healthcare policies [25]. All three of these types of barriers lead to inaccessible care by creating a judgemental environment that stops people from seeking care, placing healthcare facilities out of reach of many Indigenous communities and creating financial barriers.

Some of the strategies to mitigate these barriers include the allocation of financial support for infrastructure development in Indigenous communities, increase in teachers and education in Indigenous communities, development of culturally sensitive medical systems, and more involvement of Indigenous Peoples in policymaking [25]. Community-based facilities could play a huge role in providing equitable and accessible healthcare to Indigenous communities as well. Placing these facilities within Indigenous communities, staffed by healthcare professionals who have cultural competence, can significantly enhance healthcare accessibility for this population. Moreover, community centers dedicated to Indigenous teachings and knowledge, located in urban areas beyond Indigenous communities, can serve as safe spaces for those living away from their home communities, fostering a sense of cultural connection and support.

Lastly, youth populations can be particularly susceptible to inadequate and inaccessible care when lacking a proper support system that can provide for them. Some of the major barriers they can face are inaccessible facilities, covering costs on their own, struggling for parental involvement and advocation, and stigmatization from parents when needing mental healthcare which stops them from seeking help [26]. One study performed by [26] discusses the implementation of community-based integrated youth service hubs to address these barriers. Key characteristics of these service hubs include early intervention (for drugs and addiction), youth-friendly environments, non-medical professionals trained to deal with youth and provide care, and youth-friendly services that target the main issues faced by youth, such as mental health services, drug and addiction services, tutoring services, etc. These youth hubs have been proven to be successful resources in high-income countries. A prominent example of a youth hub is the ACCESS Open Minds youth hub in Canada, which transformed traditional mental health care by prioritizing community-focused practices to enhance health outcomes and address deficits in youth mental health practices [26]. These youth hubs are a great example of community-based care because they provide care to this population when and where they need it, making it more accessible and providing a warm handoff for these youth to flourish in society.

Given that one of the biggest barriers faced by many populations is stigmatization, the implementation of anti-stigmatization programs would be extremely beneficial to the HKPR communities. There is a wide range of programs for combatting stigmatization across Canada, and [27] identifies common characteristics among them. Programs typically include six key elements: recovery emphasis, testimonies from speakers who have experienced mental health issues in the past, education regarding social contact, myth-busting, instruction on coping skills for challenging situations, and support programs. Programs that integrate social contact (facilitating interactions with community members) and place a strong emphasis on recovery have proven particularly effective in reducing stigmatization among healthcare providers. All six key elements have been validated and demonstrated to be effective in various Canadian communities [27]. Programs such as these would aid in making care more accessible because it would help create a more welcoming and accepting environment and would encourage more groups to reach out and seek care, thereby making community-based care available to more clients.

Another access challenge faced by virtually all populations is a lack of awareness about current services. If individuals are not aware a service exists, it automatically becomes inaccessible because clients cannot seek it out. According to a study conducted by Jorm and colleagues, enhancing delivery requires improved health literacy among the public [28]. Currently, there are gaps in the public's knowledge of how to prevent health issues and mental illnesses, recognition of when a disorder or disease is developing, knowledge of help-seeking options and treatments, knowledge of effective self-help strategies, and first aid skills to support others. Various interventions can help bridge the knowledge gap and improve mental literacy, for example, whole of community campaigns, interventions in educational settings, mental health first aid training, and web-based interventions [28]. In addition to these interventions, the article recommends mental health literacy become a national policy goal to monitor trends. Strengthening mental health literacy will increase awareness of available services and empower the public to advocate for necessary care, thereby enhancing the accessibility of community-based healthcare.

Developing collaborative engagement of supportive stakeholders is also essential to successfully make community-based healthcare more accessible [29]. Oftentimes, stakeholders are reluctant to provide support because typically, community-based care facilitates are not-for-profit organizations that do not produce as much money. Therefore, if there is no one to fund these, services will not be available and consequentially, inaccessible. To address this issue community workers, have to make a compelling case and convey how beneficial these services are. A study done by Thornicroft and colleagues discusses common mistakes when implementing community-based care: not collaborating with hospitals about issues or space availability, there needs to be a balance between primary care and community-based care, not including all stakeholders in system reformations, inappropriately linking healthcare with the narrow ideology of political interests and neglecting patients' physical health [29].

Another vital component of accessible community-based care is proper funding, which can be difficult to obtain, and even when there is adequate funding, it is typically concentrated on inpatient funding [29]. To address this, funding should be allocated across all aspects of care, and payment models should be adjusted based on the population served. In addition, the issue of how to pay public providers if there is no source of income from facilities becomes a growing concern. This challenge can be addressed by payment of global budgets for facility programs and modulating budgets based on the population facilities catchment area for hospitals. The challenge of training community workers is compounded by a lack of training space and educators in many communities, further making care inaccessible as fewer people can provide it [29].

Additionally, there exists a lack of awareness among service providers regarding the access barriers faced by certain populations. Without recognizing these challenges, organizations are unable to devise effective solutions to enhance the availability of care. The City of Hamilton has faced this exact problem and in response, they created a project called Code Red which engaged communities in health systems updates and changes. The municipal government launched a multi-step project that asked community members what their biggest barriers were and the reasons for experiencing disparities. From community responses, health officials were able to find beneficial solutions that fostered the creation of more accessible options for individuals in Hamilton, for example, the re-location of healthcare facilities to more accessible locations. This project was so successful that the authors earned national attention and won local and international awards [30].

Overall, this project helped providers gauge what barriers actually and currently exist in their communities to create real-time and effective solutions. By publishing information about health disparities among communities to the public, health officials were able to implement their feedback on how to make care more accessible, which benefitted the community [30]. A similar project could be beneficial to the Peterborough/HKPR region.

Effective communication among community-based care providers is paramount for ensuring high-quality and accessible care as well. However, the current state of interdisciplinary communication among these providers often falls short of the desired standards. This could be due to various factors such as lack of staff, improper technology, lack of available facilities etc. Addressing this issue would not just improve access to care, it would reduce healthcare costs through reducing service duplication and provide more equitable care [31].

One solution to address the lack of interagency collaboration is the use of information communication technology (ICT). ICT is a set of tools that can be used to store, share, and exchange crucial healthcare information [32]. In the context of community-based care, Information communication technology would enable organizations to easily collaborate and communicate with each other by utilizing a resource such as the eHealth-enhanced Chronic Care model. This model offers a structured framework for the implementation of information communication technology in healthcare systems, with four key relevant components: electronic medical records, patient personal health records, telemonitoring systems, and web-based resources [33]. Although investing in these tools may require a lot of time and resources, information communication technology has been shown to improve the quality and accessibility of healthcare, improve collaboration and safety in hospitals and has proven cost-effective in facilities worldwide [47]. However, information communication technology is mainly used to share information among primary care facilities and community facilities, even though there is also a need to share information between community facilities [32]. The next steps for improving communication among service providers in the HKPR region would be to enable sharing among all organizations by expanding the information communication technology systems currently in place. The implementation of systems that utilize other types of information communication technology, for example, web-based resources, could also be beneficial in the sharing of wisdom.

Another type of technology that has proven to be beneficial to communication in a healthcare setting is blockchain technology. Originally introduced through Bitcoin for financial cases, this technology was used for the exchange of electronic coins without the need for a third party [35]. However, it has recently been repurposed for healthcare purposes. The main use of blockchain technology in healthcare is the management of electronic medical records, which are a common tool in Ontarian healthcare systems. It allows patient records to be stored in one central database making the authorized sharing of information among service providers easier, better controlled, transparent, and trustworthy [35]. There have been some concerns around privacy with this kind of technology that would need to be addressed if it were implemented. However, it is beneficial to healthcare facilities in the United States. If blockchain technology were to be used for community-based care purposes in the HKPR region, it could greatly improve communication among service providers.

Aside from technology improvements, agency dynamics have been found to improve agency coordination. In more recent years, the Quebec government has recognized the need for interdisciplinary communication to improve their community-based care efforts. As a result, their healthcare framework has been adjusted recently to improve interdisciplinary communication among primary healthcare facilities and community healthcare centers. Since Quebec has been successful in this discipline, the study conducted by Sicotte and colleagues explores what they have done. The interdisciplinary collaborative service delivery model that is used by Quebec healthcare systems, emphasizes collaboration among groups in which professionals share goals, make collective decisions and share responsibilities [36]. There are three groups of factors that contribute to the success of this delivery model, contextual, intragroup, and output factors. Contextual factors describe the environment people are working in needs to be inclusive and organized, intragroup factors describe the relationship among group members, and output factors describe the group's work performance [36]. The study found that the viability of interdisciplinary communication is correlated to work group internal dynamics, which is determined by the factors above. Therefore, when improving communication among service providers in the HKPR region, it is important to consider working relationships among organizations.

In terms of improving both interagency coordination and care accessibility, Evaluating the effectiveness of the suggested improvements is crucial. Sirgy and colleagues propose a validated quality-of-life assessment tool to measure community satisfaction [37]. This tool assesses community satisfaction by having community members rank various aspects of community-related life, community life, and overall life in four sample groups: community-related life sub subdomains, community life subdomains, community life domain, and overall life domains [37]. This model has proven successful in various U.S. cities, such as Hampton Roads, Virginia, where it identified public dissatisfaction with education, leading to positive changes [37]. Employing this model can effectively evaluate services in the HKPR region to inform providers of gaps in their services.

This literature review revealed gaps in service provision in terms of inaccessible care and lack of interagency communication. Through the exploration of barriers, care delivery, and improvements, community-based care has the capacity to mitigate health disparities and promote equitable access to quality healthcare services, addressing the social determinants of health that affect vulnerable populations. However, there is a lot of work to be done to ensure these disparities are further reduced, and clients are receiving the best care possible.

Overall, the purpose of this research is to enhance community-based care practices by improving interagency coordination, and care accessibility by evaluating service models, current services, communication platforms and collaboration efforts. The findings from this review will help to synthesize recommendations in order to create suggestions for these improvements.

Ethics

This project involved interviews with human subjects to gather insights on various aspects of community-based care in the HKPR region. Participants were asked about their opinions on current care methods, the feasibility of new approaches identified, resources to enhance coordination among service providers, shortcomings of the current healthcare system, and potential ideas for implementing community-based care in the region.

The Interviews were conducted with agencies serving the populations of interest, such as the HSJCC and CMHA, rather than directly with marginalized individuals. As a result, there are no safety concerns to address, as participants will be relaying perceived experiences of others rather than their own. There was little risk of emotional, psychological or physical harm since the focus group is not being conducted with the populations of interest. In addition, the questions posed were very general, and do not require information about specific individuals to be disclosed.

To ensure ethical conduct, all participants were given the choice to participate and the option to withdraw at any time. If a participant chose to withdraw, their contact information and responses were promptly destroyed. Those who agreed to participate were provided with a detailed consent form outlining the purpose and process of the study that needed to be signed before participating, ensuring transparency. Participants were also informed of the types of questions beforehand to facilitate informed consent.

Although personal information was requested, it was not required for confidentiality purposes. Furthermore, participants' names were not mentioned in the report, and raw data will be securely destroyed upon completion of the research to safeguard confidentiality. These measures were implemented to uphold ethical standards and protect the privacy of participants.

Methodology

This research project investigated various critical factors, including barriers encountered by distinct demographic groups, different service models, and resources for inter-agency communication. Data was collected from two primary sources: scholarly articles and internet-based resources, as well as through interviews with individuals and service providers involved in community-based care. Scholarly and internet-based sources were crucial because their information helped create a baseline for evaluations, assessments and the current state of community-based care. Interviews were also extremely important as they provided perspectives and information that were specifically relevant to the HKPR community. Using a combination of information from both of these sources allowed for the creation of recommendations to improve interagency collaboration, care accessibility and community-based care overall.

The information collected varies in type and significance depending on the phase of the research. In the first phase, the literature review, the main purpose of the information collected was to aid in the initial evaluation of various aspects of community-based care. Specifically, information regarding current services in the HKPR and outside regions, existing/novel service models, barriers faced by HSJCC clientele (in the HKPR region), technological platforms and means of collaboration were gathered. This information helped create a baseline of the current state of community-based care in the HKPR region, which in turn aided in identifying existing gaps in services, communication and care in general. Once the gaps were understood, more of the same information was collected which facilitated the creation of some tentative improvements.

In the next phase of the research, the focus groups, the main purpose of the information collected was to obtain service providers' opinions of community-based care to assess whether this information supported the previous research and gain an informed perspective. More specifically, service providers were asked their perspectives regarding the strengths and weaknesses of various service models, practices, collaboration platforms etc. and improvements they thought would be effective.

In the last part of this research, analyzing the results from the focus group, further research was conducted to gain a deeper understanding of the information gathered from the service providers and to fill any gaps of questions that were not answered. The information collected in this phase was specifically regarding various types of training, services, barriers and service models as well as novel technology platforms. In addition, this information helped solidify the proposed recommendations.

The Initial phase of this research involved an extensive literature review to establish a baseline for community-based care practices in the HKPR regions, explore current and innovative resources pertinent to community-based care, evaluate barriers regarding healthcare access and examine research on coordination among service providers. Therefore, “resources” can include: the use of technology, government funding, and medical equipment. The review was synthesized from the information provided by thirty-one scholarly articles, infographics, government statistics, and reliable news sources. Subsequently, a comprehensive review of service models was conducted to assess the strengths and weaknesses of new and existing service models, determining their potential benefits for the HKPR community. This review was formed from the information gathered from scholarly articles and lists of service models provided by the HSJCC. Before proceeding with the final phase, an ethics application was submitted to gain approval for working with human subjects. Based on the information gathered from the first two tasks, a semi-structured questionnaire comprising 23 open-ended questions was developed, covering five main sections: Coordination and collaboration, service models and community-based care, population/user groups, technology and information sharing, and training, funding, and facilities.

Following the questionnaire development, community focus groups were convened on January 26th, with 23 participants in attendance. These groups facilitated discussions regarding community needs and interests related to community-based care. The target participants were agencies and employees that were members or affiliates of the HSJCC, and this was the only necessary requirement for participation. They were contacted by the host organization (Human

Services and Justice Coordinating Committee) via email and voluntarily signed up for the focus groups. The participants arrived at 9 am at the Peterborough Lions Community Centre on Burnham Street. Upon arrival, they were promptly asked to sign a detailed consent form and hand it back to the researcher. Participants were then divided by the researcher based on their roles (managerial positions and others) and agencies into smaller groups to ensure diversity and representation. Once this was successful, they were separated into three groups of six and one group of five, the researcher ensured every group had at least one manager and no more than two participants from the same agency. Next, the participants (while still in their group) were given the pre-made questionnaires to fill out individually, they were given forty-five minutes to do this. Then, they were given thirty minutes to collaborate and write down their main ideas from each section of the questionnaire on chart paper. After, each group was given five minutes to present their main ideas to the rest of the group and the researcher. Both the individual questionnaires and the group chart paper were collected. In total, the focus group lasted for an hour and a half.

The insights collected from the focus groups provide a community perspective on the subject, as well as an understanding of the communication dynamics among agencies providing these services. The decision to conduct the study in a group setting was deliberate, aiming to capture a wide array of perspectives from individuals across different positions and agencies. By incorporating both individual viewpoints and collaborative insights, the research sought to achieve a comprehensive understanding of the subject matter. The culmination of data from these diverse sources was gathered to create this comprehensive report. To analyze this data, the researcher conducted a SWOT analysis (strengths, weaknesses, opportunities and threats) on each of the sections of the questionnaire using the individual and group responses. In total, five SWOT analyses were conducted and placed into the results portion of this report. In these analyses, the main and re-occurring themes/answers were identified and reported along with a corresponding frequency for each point. The strengths and weaknesses section was purely from the questionnaire answers, whereas the opportunities and threats were a combination of participant answers and research. In addition, the strengths and weaknesses section contained statistics that portrayed how many participants spontaneously wrote the same answer. This is significant because answers were unguided, therefore if multiple said the same answer, it shows there is a consensus among respondents, provides a sense of validity and helps identify patterns and trends within data.

In this research, many biases could be encountered. Observer bias is one concern, where research participants may perceive and report what they desire, rather than objective observations. This bias could influence the accuracy of recorded behaviors and potentially result in skewed findings, undermining the study's validity. To mitigate this, the researcher solicited both individual and group opinions, ensuring a diverse range of perspectives within the group settings. Interviewer bias may manifest when the researcher's personal values shape the phrasing of questions, possibly leading to distorted responses and a lack of rapport with interviewees. To prevent this, the researcher refrained from conveying any personal opinions on the subject matter, maintaining neutrality with the participants. Another concern was researcher bias which occurs when the researchers' own beliefs or perspectives unconsciously influence the research design and data collection, potentially compromising the validity of the results. To address this, the researcher was conscious of this bias and got input from their host organization to ensure all the study elements were impartial and unbiased. Sampling bias arises when the chosen sample does not adequately represent the broader population, affecting the generalizability of the findings and limiting their applicability to various populations. While addressing this bias proved challenging, efforts were made by both the host organization and the researcher to ensure a diverse range of perspectives within the sample. Lastly, nonresponse bias may emerge when certain individuals opt not to respond, creating gaps in the results and diminishing the representativeness of the intended population. To mitigate this, participation in the group collaboration ensured that all participants contributed to the overall discussion, regardless of their level of engagement in the individual portion of the study.

Results and Discussion

To analyze the results from the research, a SWOT analysis of each section of the questionnaire was conducted. This acronym stands for strengths, weaknesses, opportunities and threats. This type of analysis is beneficial because it provides a comprehensive assessment by examining all aspects of a topic and it allows for the creation of recommendations based on these aspects. The results and implications from the SWOT analysis from each section requires further discussion, to facilitate a deeper understanding of the current state of community-based care practices, various barriers and challenges faced, potential recommendations and ways to enhance care accessibility and collaboration in the HKPR region

Service models and community-based care

Table 1: SWOT analysis of current and novel service models and care provision in the HKPR region

SWOT analysis		Frequency
Strengths	• Community hub model • Home care • Lay person model	• 12/23 • 10/23 • 8/23
Weaknesses	• Silo management	• 10/23
Opportunities	• Improved delivery of care • Consistent delivery	N/A
Threats	• Lack of knowledge about different service models among providers • Lack of evaluations and success rates of different service models	N/A

A service model is a framework that outlines the structure, process and components of care delivery, and they are imperative in providing community-based care practices. The selection of an appropriate service model is crucial as it directly impacts the quality and accessibility of care. In the HKPR regions, there exists a diverse range of service models, each with its strengths and weaknesses. Currently, various service models are successful in the HKPR regions, however, other models have not yet been implemented that could aid in the facilitation of more accessible care and warm handoffs. To assess the landscape of available service models and identify areas for improvement, a SWOT analysis was conducted, yielding insightful findings summarized in Table 1.

Strengths and weaknesses

In exploring the strengths of various service models in the HKPR region, insights from the focus group demonstrate the effectiveness of several approaches. Firstly, 12/23 people from the focus group stated that the community hub service model is successful in providing accessible care to clients in the HKPR region. Community hubs serve as inclusive spaces where residents can access a multitude of resources and services, including healthcare, social support, and cultural activities [38]. This resource benefits both agencies and clients as service providers have reported increased networking and interagency coordination efforts, and it helps clients to have more accessible care [39]. Notably, models like the ACCESS Open Minds youth hub demonstrate the success of this approach, providing youth-friendly environments and comprehensive care tailored to their specific needs. [27]. In addition, hubs does not typically come at any cost, and they are located in informal and easy to get to places. This is a prominent example of how hubs can provide accessible care with warm handoffs. By fostering networking and coordination among service providers while offering accessibility with no financial barriers, community hubs emerge as a valuable asset in addressing diverse community needs.

Secondly, home care models received recognition from 10 out of 23 participants for their effectiveness in delivering accessible care directly to clients. These are service models that provide people with care from the comfort of their homes, and include services such as meal preparation, bathing, dressing etc. [40]. Home care models have many successful elements, it is cost-effective (healthcare cost is a major barrier), they promote a faster recovery time, facilitate individualized care which can be provided with a warm handoff, and they make care more accessible because providers come to clients in their home [41].

Lastly, the Lay Person service model, highlighted by 8 out of 23 participants, successfully provides accessible care to HKPR communities. This model utilizes mobile non-medical professionals trained in specific tasks to deliver care where it is easiest for clients [8]. With a focus on individualized attention and a minimum 1:1 provider-to-client ratio, Lay Person service models address access barriers such as transportation issues and financial stress, leading to reported improvements, such as general wellness, among clients [8].

Conversely, weaknesses in service provision were identified, notably with 10/23 participants stating silo management models. These models, characterized by independent operation and limited knowledge exchange among agencies, hinder coordination and cohesion in care delivery [42]. By perpetuating a silo mindset, these models impede collaboration and disrupt the seamless delivery of care, ultimately proving ineffective in community-based care settings [43].

Recommendations and opportunities

In addition to the ones previously discussed, several new service models hold promise for improving accessibility and quality of care while facilitating warm handoffs in the HKPR communities. Firstly, the implementation of Community-based forensic teams could offer valuable support to individuals transitioning from or going through the justice system. These teams, operating under Parallel, Integrated, or Sequential Intercept models, focus on providing alternative forms of care to offenders by emphasizing community reintegration and support. The

Parallel and Integrated models both describe using the services of forensic mental health specialists working on either community or separate mental health teams to provide the population with a variety of community-based services that would help them reintegrate into society [12]. These models differ in physical location, management, caseload, and referral procedures, however, both of these focus on specialized community interventions for mentally ill offenders. The sequential intercept model operates on the basis that offenders should be eligible for alternative treatment (as opposed to being jailed) even if they are deemed fit to stand trial. Typically, in courts in the United States, most offenders will only receive alternative treatment if they are deemed unfit to stand trial. This is an unrealistic approach for courts to follow because there are many people who although are fit to stand trial, still deserve to be eligible for alternative treatments. It also emphasizes allowing alternative intervention at any point in the criminal trial [11].

Overall, both of these models aim to improve the delivery and accessibility of care. They allow for providers to better focus on the specific populations of individuals in or exiting the justice system who are struggling with mental health rather than having mental health teams that service all populations. This increases the accessibility of mental healthcare for this specific population because resources and providers are not stretched so thin trying to provide for everyone. In addition, these models place a strong emphasis on re-integration into society, once clients are ready. Therefore, these models aid in facilitating warm handoffs for clients.

The Balanced Care Service model presents an opportunity for improving care accessibility by ensuring an equal provision of community-based and primary care services. This model would allow for more accessible care by providing more community-based services such as mental health teams, outpatient clinics, long-term community residential care etc. while preventing the overwhelming of primary care systems [18]. Although not implemented in Canada, it has been found successful in other high-income countries and therefore has the potential to be a successful recommendation.

This research has found that Palliative care models are another recommendation that could improve care accessibility while providing warm handoffs. Its framework aims to reduce suffering and improve the quality of life for those who are terminally ill. This type of care has been found to be extremely useful to this population and has the potential to be successful for non-terminally clients as well. In general, palliative treatment includes around-the-clock care from trained professionals and emphasis on providing comfort. For non-terminally ill patients this model would provide client-centred care by involving them in treatments and decisions, having a cohesive healthcare team that can coordinate care and employing a more holistic approach which takes into account emotional and physical well-being while providing clients with a place to stay [44]. For this recommendation to be successful, this type of care should integrate primary and community-based care resources which would help provide comprehensive and adequate treatment. This model improves accessibility of care by providing a common community location for clients where all of the necessary treatment is in one place [44].

Paramedic care models emphasize using trained professionals (paramedics) to apply their skills in non-traditional community-based settings and non-emergent and emergent situations. Services provided with this model could include, mental health care, physical care, medication administration, and drug overdose responses [45]. This promotes accessible care because paramedics would be going to the clients to provide care, this would be especially helpful for rural populations in the HKPR region. O'Meara et al found that this model has been implemented in Ontarian counties, such as Renfrew, and has been found to be successful if the following elements are incorporated: response to emergencies, community engagement, situated practice, primary and integrated care, governance and leadership, higher education and treatment and transport options [45]. This recommendation has great potential to benefit the HKPR community to make care more accessible.

Lastly, the use of specialized courts has the potential to provide better care with a warm handoff. Specialized courts are those that address specific issues such as drug, sexual assault, domestic violence and Indigenous Peoples courts. Instead of being motivated by penal punishments, they operate using preventative and therapeutic goals that rely on relationships with local community providers [46]. These providers can administer alternative treatments and monitor individuals to ensure they are receiving the care they, so they do not re-offend. General courts do not allow for tailored services; therefore, these courts only operate on one issue, which means they can provide individualized approaches to address specific challenges. There are specialized courts within Ontario that are successful, therefore there is a high likelihood, that this would benefit the HKPR community as well. By collaborating with local community providers, these courts facilitate alternative treatments and support clients' reintegration into society, ultimately providing warm handoffs and promoting better outcomes [46].

The successful Implementation of these recommendations presents two significant opportunities for the HKPR region. Firstly, they offer the potential for improved delivery of care. Community-based care emphasizes the provision of timely and tailored treatments to clients, necessitating the utilization of diverse service models. As noted by [10], there exists no singular universal model of care; instead, each community and population possesses unique needs requiring individualized solutions. By utilizing these recommendations, agencies can enhance the delivery of care, making it more responsive to the specific needs of clients. Moreover, this improvement in care delivery could lead to increased accessibility, ensuring that services are more readily available to those in need. Furthermore, the adoption of multiple service models equips agencies with the tools necessary to provide warm handoffs, facilitating transitions between care providers and enhancing the overall client experience.

Secondly, the implementation of these recommendations could foster more consistent delivery of care, thereby ensuring quality assurance, efficiency, and equity. By utilizing a variety of service models, agencies can establish a framework that promotes standardized practices while remaining flexible enough to address the diverse needs of clients. This consistency in care delivery is essential for optimizing treatment outcomes and ensuring that all individuals receive the highest quality of care. Additionally, by promoting efficient and effective treatment approaches, these recommendations enable agencies to maximize their resources and redundant services, ultimately enhancing the overall efficiency of community-based care practices.

Threats

One of the primary threats to implementing and improving service models is the lack of knowledge among providers about the various options available. This deficit in knowledge poses a significant risk to client well-being, as it may result in suboptimal care delivery. Without awareness of different models, providers may inadvertently use approaches that are not best suited to meet the needs of their clients, leading to inefficiencies in care provision. Moreover, this lack of knowledge could contribute to inequitable access to care, particularly for marginalized communities, as providers may not utilize models that could effectively address existing health disparities. Additionally, the absence of awareness about alternative models may hinder the achievement of optimal outcomes, as providers may overlook potentially more effective approaches simply due to a lack of knowledge.

Another notable threat to implementing service models is the lack of evaluation or documented success rates for certain approaches. For instance, models like the integrated/parallel and sequential intercept model have only undergone limited evaluation in communities outside of Ontario. This lack of robust evidence may lead to skepticism among providers, deterring them from adopting these models due to fears of failure and concerns about potential negative impacts on care provision and accessibility. However, without experimentation and evaluation, it remains unclear whether these models could indeed enhance care accessibility and improve outcomes for clients.

Population/user groups

Table 2: SWOT analysis of services provided to vulnerable populations in the HKPR region and the barriers they face.

SWOT analysis		Frequency
Strengths	• Currently all user groups are in need of better services • Good examples - Mobile crisis intervention team - 360 NPC	• 23/23
Weaknesses	• Elderly • Racialized • New Canadians • Rural	• 10/23 • 9/23 • 6/23 • 5/23
Opportunities	• More encompassing care • More groups served equally	N/A
Threats	• Stigma • Lack of transportation • Financial • Clients may not have access to online options	N/A

In community-based care, services must be able to address the distinct needs of specific populations and multifaceted issues affecting different groups. To do so, providers must identify both common and unique barriers encountered by each group. By understanding these access barriers, providers can strategically select appropriate service models and develop tailored interventions to facilitate positive outcomes for their clients. Furthermore, in addressing these challenges providers can work towards eliminating disparities in care access and promoting equitable access to services for all members of the community. A SWOT analysis was conducted to evaluate the barriers, and the results can be summarized in Table 2.

Strengths and weaknesses

All 23 participants in the focus group unanimously emphasized the pressing need for improved and more accessible care across all populations. Despite this overarching need, there were notable examples of successful services that effectively cater to the diverse needs of clients. One such example is the Mobile Crisis Intervention team, a collaborative effort between mental health nurses and police forces, which responds to 911 emergency calls as a unified team [47]. These teams are resourceful because neither party could handle these situations on their own. With approximately 90% of police forces implementing these teams, their effectiveness is evident, with reported reductions in arrests by up to 70% in areas such as Hamilton [48]. This service is successful in providing accessible care by delivering services directly to individuals in need, ensuring timely and targeted interventions.

Another notable example is the 360 Nurse Practitioner Clinic, located in Downtown Peterborough, which serves as an accessible healthcare hub for all populations. Staffed with a diverse team of professionals including nurses, dietitians, and social workers, the clinic offers comprehensive and coordinated care to all individuals [49]. By providing a range of services in a central and easily accessible location, this clinic demonstrates equitable care provision.

While all populations require more attention, certain groups were identified as disproportionately underserved by the participants. Among these groups, the elderly emerged as a top concern, with 10 out of 23 participants highlighting their vulnerability to inadequate care. Additionally, racialized communities (9/23), new Canadians (6/23), and rural populations (5/23) were identified as facing unique barriers to accessing proper care. Understanding and addressing these barriers is crucial to ensuring equitable access to care and addressing the specific needs of these marginalized populations.

Recommendations and opportunities

There are several ways in which existing services could be enhanced to better provide for underserved populations. Among the populations identified as most underserved, lack of transportation emerged as a significant barrier, impacting access to care and exacerbating health disparities. As highlighted by Syed et al., transportation limitations contribute to missed appointments, delayed care, and ultimately, poorer health outcomes and is of particular concern to elderly populations [50]. To address this challenge, the HKPR region must enhance existing transportation services. While some community providers currently offer transportation assistance, they are primarily targeted to the elderly population within the Peterborough area, therefore limiting in scope and availability [7]. Expanding this service to encompass a broader range of age groups and populations, with increased coverage across the region, would improve care accessibility by providing clients with the means to reach vital appointments and services.

Aside from transportation issues, rural populations face unique challenges due to geographical isolation and lack of nearby healthcare facilities and resources [17]. To address these barriers, one proposed recommendation is the implementation of safe meeting sites in rural areas that could significantly enhance accessibility to community-based care practices [17]. These sites could serve various purposes, including facilitating drug and alcohol meetings and providing safe spaces for victims of various crimes, thereby bridging the gap in service provision for underserved rural communities.

Since racialized groups were identified as disproportionately underserved, recommendations that suggest how to improve their quality of care are greatly needed. One identified by this research is the implementation of the Culturally competent Community Care model. This service model prioritizes cultural sensitivity, knowledge, and skills among providers, fostering trust and engagement among diverse populations to equip agencies with cultural competence [11]. By ensuring that care is delivered in a manner that respects and acknowledges cultural differences, these models not only enhance accessibility for racialized groups but also extend benefits to new Canadians and immigrants, fostering inclusivity and promoting positive health outcomes. In addition, this model has been shown to increase the number of ethnic groups that reach out for care and have positive health outcomes [11]. Therefore, cultural competence makes care more accessible by showing racialized groups that they will not be discriminated against, making it more likely they will seek treatment.

Although many barriers faced by populations are well known and documented, service providers still report dealing with new challenges every day. Therefore, agencies would greatly benefit from creating an initiative similar to Hamilton’s Code Red Project. The first phase of this project was the identification and description of disparities in health determinants and barriers experienced by various Hamilton communities. From this research, investigators found significant variations among determinants in health and health outcomes across different neighbourhoods [30]. The Hamilton Spectator, a local newspaper, published these results along with supporting statistics, maps of neighbourhoods, and relevant interviews and stories that relayed the situation. This sparked public and political debates about reasons for the variation, wasted healthcare resources, the need for alternative care options to emergency rooms, and the fragmentation of health and social services. The results of this study had an extremely positive impact on the city. In response to the project's findings, McMaster University made the decision to relocate its medical center and Children's hospital to an area of the city that was more accessible and was identified by the Code Red project as an area characterized by high poverty rates. Additionally, McMaster University introduced new courses that incorporated the Code Red findings as part of the curriculum. Recognizing the need, a new position in the municipal government was created in response to the project findings to develop a strategy to address the issues regarding access identified by the research [30]. Given its proven success, this project holds considerable promise in enhancing accessibility for clients if the HKPR region were to engineer a similar project.

In addition to initiatives like the Code Red Project, there are broader recommendations to improve the accessibility of care for all populations. Transitioning away from office-based services is one such strategy. Statistics indicate that while approximately 70% of Canadians own or have access to a car [51], nearly 92% have access to some form of phone and wireless services [52]. These statistics demonstrate the accessibility of online care options, such as virtual meetings, which are more feasible than in-person appointments for many Canadians. Although many agencies already offer online services, expanding this approach could significantly benefit clients. Furthermore, operating on a case-by-case basis can enhance the quality of care by providing tailored services, more attention to detail and efficiency in finding solutions. Improving quality of care also improves accessibility by promoting client participation, improving health outcomes and enhancing patient satisfaction.

Ultimately, successful implementation of these recommendations would lead to more comprehensive care that serves diverse groups equally. To further alleviate barriers for underserved populations such as the elderly, rural residents, racialized, and new Canadians, more agencies must adopt accessible transportation services and broaden their distribution areas.

Threats

The threats faced in terms of implementing the recommendations are the barriers faced by each population. While some barriers have been addressed in the proposed solutions, others present more obstacles that are difficult to alleviate. For the elderly, unique disadvantages stemming from age-related concerns and generational values often impede their acceptance of care. Additionally, they contend with challenges such as limited transportation options, financial constraints, and the absence of round-the-clock care facilities [23] [24]. Racialized populations encounter significant barriers due to stigma and apprehensions about encountering racism within our healthcare system [53].

New Canadians face a multitude of hurdles, including language barriers, unfamiliarity with available services, geographical inaccessibility, and cultural disparities [54]. Similarly, rural populations grapple with obstacles such as transportation deficiencies, social isolation, and a scarcity of nearby healthcare resources [17]. All of these barriers impede access to healthcare for the respective populations and pose challenges to service providers to help individuals overcome them.

Moreover, the successful implementation of most recommendations relies on securing additional funding—a challenge in itself. Insufficient financial resources could impede progress in enhancing accessibility and care quality. Additionally, there remains the risk that certain clients may lack access to phones or wireless connections, rendering virtual care options impractical or inaccessible.

Service coordination and collaboration

Table 3: SWOT analysis of the state of interagency coordination and collaboration practices in the HKPR region.

SWOT analysis		Frequency
Strengths	• Written consent forms for interagency collaboration • HSJCC • Situation tables	• 10/23 • 6/23 • 10/23
Weaknesses	• Lack of case management • Lack of opportunities to learn about resources for clients and providers	• 8/23 • 7/23
Opportunities	• Enhanced interagency coordination • Streamline referral processes • Meeting clients' needs more accurately • Better education opportunity • Combination of resources	N/A
Threats	• Lack of funding • Lack of respect/willingness to accept one another limitations • Lack of participating agencies	N/A

Communication and coordination among service providers and agencies is a vital component in providing adequate community-based care. Clear communication fosters understanding, minimizes misunderstandings, and facilitates problem-solving and conflict resolution, laying the groundwork for care provision. By collaborating with various services, providers can ensure that clients receive the best possible care that is tailored to their needs. However, the current state of coordination among service providers reveals shortcomings that impede care delivery and compromise client well-being. To address this issue, a SWOT analysis was conducted which can be summarized in Table 3.

Strengths and Weaknesses

Firstly, in examining the strengths of this topic, it's evident that several key aspects contribute to effective communication and coordination among service providers and agencies. Among these strengths, 6 out of 23 respondents highlighted the pivotal role played by the Human Services and Justice Coordinating Committee (HSJCC). The HSJCC is an organization that provides a network for providers to have access to shared resources and services, and to coordinate with other agencies [55]. This is an example of a structure that allows for coordination because it fosters collaborative problem-solving and provides access to resources that may not have been so easily accessible otherwise within a common space. This model is so successful in terms of collaboration because of its "shared responsibility and accountability" element which emphasizes communications and a multi-service approach, rather than providing care alone or from just one service.

Another notable strength highlighted by 10 out of 23 respondents is the utilization of written consent forms for interagency communication. A written consent form, in terms of community-based care, is a document that is drawn up by a service provider which states that if a client signs it, they consent to having their information shared with other providers. These are a good resource for coordination for many reasons. These forms streamline the information-sharing process which expedites communication by eliminating the need for clients to authorize information release at every juncture. Moreover, as legally binding documents, consent forms ensure compliance and facilitate seamless data sharing among providers.

Lastly, community situation tables emerged as another beneficial resource, with 10 out of 23 respondents recognizing their efficacy. These tables serve as communal forums where local residents and service providers convene to address community issues collectively. By consolidating multiple providers in one physical space, community situation tables enhance communication and coordination, fostering more efficient collaboration and resource utilization.

Despite these strengths, several weaknesses were identified by respondents. For instance, 8 out of 23 individuals expressed concerns regarding the lack of opportunities to discover new and available services for both providers and clients. If providers are unaware of possible services or other providers, it could hinder interagency communication in various ways. For example, without knowledge of other agencies, there would be a lack of coordination and sharing of resources, and there would be gaps in service provision because certain client needs may remain unmet due to the lack of awareness and fragmented delivery service because often, one service is not fully equipped to provide the full range of care for a client. Without adequate knowledge of available resources and providers, clients' needs may remain unmet, undermining proper delivery.

Moreover, 7 out of 23 respondents reported a deficiency in case management and follow-through as a significant weakness. Many cases necessitate similar approaches and solutions, yet the absence of effective management leads to overlooked details and a lack of communication among agencies. In addition, without proper case management, crucial information about clients may not be relayed to service providers, which hinders coordination. Miscommunication is also an important issue that would likely arise from this weakness. All of these would negatively affect client outcomes and the provision of care.

Recommendations and opportunities

In addressing the identified weaknesses, this research offers a range of strategic solutions aimed at enhancing communication and coordination among service providers and agencies. The first recommendation is the establishment of an umbrella committee tasked with overseeing interagency communication, data collection, and identification of service gaps. By centralizing communication through a single platform, this committee would ensure consistency and efficiency in coordination among providers [56]. Moreover, by coordinating service resources, the committee would facilitate easy access to care and enhance collaboration across agencies. In addition, shared resources can lead to better allocation, so clients are receiving the care they need with a warm handoff [56]. The adoption of an umbrella committee model not only streamlines communication but also promotes a cohesive and comprehensive approach to care delivery, ultimately benefiting clients by ensuring equitable and consistent treatment.

Community situation tables were identified as a strength; however, they are not employed by all agencies. This is a structure that has been found to be extremely successful in Peterborough, as well as in other Ontarian regions. The City of Waterloo found that community situation tables were effective at addressing various community issues such as mental health and addictions, youth services and homelessness. Service providers have also reported enhancements and improvements in how they engage in agency coordination [57]. Drawing from successful experiences in regions like Peterborough and Waterloo, these tables serve as invaluable forums fostering collaborative relationships among service providers. By instituting regularly scheduled community situation tables, agencies can enhance coordination, share best practices, and improve outcomes for clients.

In addition to structural enhancements, the implementation of information management systems would likely further support coordination and collaboration efforts. These systems play a crucial role in collecting, storing, and disseminating data, thereby facilitating communication among stakeholders and agencies [58]. By providing a centralized platform for data sharing, these systems could improve the efficiency and effectiveness of interagency coordination and care provision. If a resource such as this could be made available without charge, or at a lower cost, this would improve coordination and collaboration even further.

Moreover, to address the lack of awareness about new services, another recommendation from this research is to increase networking events tailored to service providers. This could be an educational resource that allows for increased communication by providing chances to learn about new services and in common space for agencies to discuss issues, ideas etc. together.

Networking events have been proven to initiate new connections and improve communications with previous contacts [59]. An approach to better networking events is stated in the article by Mandeno and Baxter, where they lay out 6 principles that ensure successful networking events. These principles include contextual ambiguity, uniformity, comfortable vulnerability, structural simplicity, proximity and actionable permissibility. By fostering a culture of collaboration and knowledge sharing, networking events empower providers to stay informed about available services, ultimately enhancing coordination and improving client care [59].

Implementing these recommendations offers numerous benefits and opportunities for the HKPR region. Firstly, service providers would be able to meet client needs more accurately and efficiently. Enhanced communication and coordination would enable service providers to meet client needs more accurately and efficiently, leading to more consistent and comprehensive care delivery. In addition, this would also allow for the combination of resources. By improving means of communication and collaboration, such as having an umbrella committee, agencies have the opportunity to have all resources in one place/network. This would be extremely beneficial because it would enable cost savings by reducing the need for redundant services, increases accessibility for service providers, facilitates better coordination among providers because everything is in one place and allows for better allocation of resources [56]. Overall, when resources are optimized and more accessible, care for clients also becomes more accessible, timely and efficient. Furthermore, using the recommendations to improve communication and coordination could produce streamlined referral processes and reduce wait times. According to Lewis et al., slow referrals and long wait times are among the biggest barriers faced by community members when trying to access health care [60]. By optimizing resources and streamlining referral processes, wait times can be reduced, improving accessibility and timeliness of care.

Additionally, better education opportunities through networking events would empower providers to stay informed about available services, facilitating more effective coordination and ultimately improving the quality of care for clients. Overall, the recommendations aid in improving coordination among agencies by providing shared resources, common spaces, education opportunities, and shared networks. All of this would in turn benefit client care in various aspects such as care coordination, consistency delivery and quality.

Threats

When considering threats to interagency coordination and collaboration, several significant challenges were identified, posing potential barriers to the implementation of proposed improvements. Foremost among these threats is the issue of inadequate funding, as reported by respondents. While the recommended strategies hold promise for enhancing communication means, the lack of financial resources presents an obstacle. Without sufficient funding, the necessary infrastructure, resources, and support systems may not be accessible, hindering the implementation of improvements and impeding progress toward more effective coordination and collaboration.

Additionally, the lack of respect among agencies emerged as a prominent concern. In some cases, agencies may fail to acknowledge or value the contributions of other organizations leading to strained relationships and reluctance to engage in meaningful communication. Overcoming this challenge requires fostering a culture of mutual respect and appreciation for diverse perspectives, which can be challenging to achieve but is necessary.

Furthermore, the reluctance of some agencies to participate in implementing recommended improvements poses a significant threat to progress. Without active engagement and commitment from all stakeholders, initiatives aimed at enhancing coordination and communication may struggle to gain traction and achieve the intended outcomes.

Technology and information sharing

Table 4: SWOT analysis of current and novel technological and information sharing platforms used by service providers in the HKPR region

SWOT analysis		Frequency
Strengths	• Email/phone • Zoom - Moving things remotely • Social media	• 11/23 • 17/23 • 5/23
Weaknesses	• Emails, phone calls and text messages can go unseen • Information can get easily lost online	• 7/23
Opportunities	• Sharing of knowledge and information • Improved coordination and collaboration among agencies	N/A
Threats	• Not many service providers are aware of alternative technology options or know how to use it	N/A

Effective interagency coordination is paramount to providing accessible and equitable care. Utilizing the proper technology is crucial for successful coordination and communication. When this aspect is lacking, various barriers are introduced that hinder interagency collaboration and in turn, quality of care provision. A SWOT analysis was conducted to evaluate the current state of technology and information sharing platforms, and the results can be summarized in Table 4.

Strengths and weaknesses

The consensus among the majority of focus group participants demonstrates the value of online platforms and communication tools in enhancing information sharing and coordination efforts. Specifically, 11 out of 23 individuals highlighted the benefits of email and phone calls, 17 mentioned the advantages of platforms like Zoom and Microsoft Teams, while 5 individuals emphasized the utility of social media. In terms of collaboration, online platforms and instant messaging allow for instant communication and responses, this can improve coordination because matters can be discussed from any place at any time. Moreover, online platforms promote more accessible care by providing clients with convenient access to services from the comfort of their homes, along with rapid and efficient communication. Social media, in particular, offers a unique avenue for engaging younger demographics while effectively communicating important information.

However, despite the numerous benefits of technology, it is not without its flaws. As reported by 7 out of 23 participants, instances of missed phone calls, emails, and text messages can impede coordination efforts. When messages go unnoticed or unanswered, it can lead to delays in communicating and the provision of care or solutions.

Recommendations and opportunities

To enhance information sharing and communication, it is imperative to provide more opportunities for agencies to learn about new and available platforms. For instance, organizing agency-wide seminars led by knowledgeable employees could effectively inform others about useful technological options. Subsequent standardized training sessions on these platforms would then ensure that agencies comprehend how to operate them efficiently. Moreover, having a designated information technology (IT) employee within each agency to navigate research on new platforms and conduct educational sessions would greatly facilitate the implementation of these recommendations. While some agencies, like the HSJCC, have already adopted this approach, its widespread implementation would undoubtedly benefit all agencies.

In terms of new technological platforms that could enhance information sharing, this research has identified two promising options suitable for the HKPR region. Firstly, the utilization of blockchain technology in healthcare could improve coordination among agencies by establishing centralized online databases for electronic medical records, which are a common tool for information sharing in Ontario's health system [35]. Using this platform would greatly improve coordination among agencies because patient information would be in one accessible online location. Similarly, the eHealth-enhanced Chronic Care model offers many of the same benefits. It creates a shared online space for electronic medical records, patient personal health records, tele-monitoring services and web-based resources [32]. To implement an effective information communication system, some requirements need to be met: having a tested, user-friendly and intuitive system, the ability to train workers to use the system, a competent information communication leader, and team and medication order/ patient record entry that is not difficult to transfer to the system [33]**.** These platforms have been found to be successful in the United States, for primary care facilities, but they could be adapted for community-based care agencies. Both technologies would promote improved coordination by providing shared databases accessible to multiple organizations, eliminating the need for constant data requests. When examining potential privacy concerns associated with information, the use of signed consent forms, as mentioned as strength in Table 3, could address this issue, allowing agencies to share and access client information without requiring approval at every step. Overall, using these recommendations to improve coordination would in turn improve quality and accessible of care as well.

Threats

Although successful implementations of these recommendations hold promise for improving information sharing, coordination, and care provision, several barriers exist. Primarily, there exists a pervasive lack of knowledge among service providers regarding new technology platforms. When surveyed about their awareness of alternative platforms, 23 out of 25 participants reported being unaware of any. This widespread lack of awareness highlights the extensive gap in knowledge concerning novel technology options. This deficiency in awareness may impede effective coordination among agencies, particularly if superior alternatives are available but remain unrecognized. Moreover, even if alternative options were identified, many service providers lack the necessary understanding of how to utilize new technology effectively, thereby rendering the implementation of novel platforms even more difficult.

Furthermore, lack of funding poses a significant threat to achieving adequate information sharing. While it was recommended that agencies designate a technology specialist, the financial constraints may render this suggestion unfeasible. Additionally, budgetary constraints may not allow for the acquisition of new technology altogether.

Training, funding and facilities

Table 5: SWOT analysis of current state of training, funding and facilities used by service providers for community-based care practices in the HKPR region

SWOT analysis		Frequency
Strengths	• General healthcare training	• 3/23
Weaknesses	• Lack of interagency training • Lack of naloxone training • Lack of management training • Lack of technology training • Facilities don’t allow for coordination • lack of funding	• 7/23 • 5/23 • 6/23 • 4/23 • 5/23 • 17/23
Opportunities	• Improved consistency is healthcare delivery • Better allocation of resources • Greater access to services • Access to multiple providers at once	N/A
Threats	• Lack of staff • Limited resources • Financial restrictions	N/A

Effective community-based care practices rely on several key components, including training, funding, and facilities. Comprehensive training ensures that care providers are equipped to deliver the highest quality of care, while efficient communication fosters coordination among stakeholders. Adequate facilities are essential for accommodating resources and facilitating interactions between clients and agency personnel. To support these elements, sufficient funding and a flexible budget are imperative. A SWOT analysis was conducted to evaluate where training, funding and facility aspects thrive and fall short, the results can be summarized in Table 5.

Strengths and weaknesses

Only a small fraction of participants in the focus group, specifically 3 out of 23, indicated that general healthcare training is currently adequate. The lower levels of general healthcare, such as CPR, are relatively easy to get and therefore, more people are trained in this. However, 3/23 is still a small portion of the group, which indicates that this kind of training still needs more attention. Notably, there were no other aspects of community care that were highlighted as well-trained. This is significant because it demonstrates the critical need for enhanced training in all aspects, resource allocation, funding, and facility provisions to ensure optimal care delivery and effective coordination.

Among the areas requiring the most improvement, 7 out of 23 participants highlighted the need for increased interagency training. Interagency collaboration is essential in community-based care, yet the lack of coordination among agencies suggests a deficit in this area. Without proper training on how to communicate effectively with other agencies, clients may experience delays in care, inadequate follow-up, and a lack of support. In addition, 5/23 participants report that there is a lack of naloxone training among HKPR providers. Naloxone is a medication that can reverse the life-threatening effects of an opioid overdose [61] and is essential considering that the Peterborough region has been issued a drug alert for opioid overdoses [62]. Based on this information it is clear that increased naloxone training is compulsory to successful care provision. Similarly, 6 out of 23 participants identified a lack of managerial training, which can complicate coordination efforts due to unclear responsibilities as to who has what role and is meant to be the point of communication.

Insufficient technology training, as reported by 4 out of 23 participants, further impedes communication and coordination efforts. Regarding facilities, while individual agencies may have adequate resources within their own premises, 5 out of 23 participants noted that these facilities may not facilitate coordination with other organizations. Additionally, the majority of participants, specifically 17 out of 23, expressed concerns about funding shortages for essential resources such as additional staff, improved equipment, expanded facilities, and educational opportunities. These funding limitations can negatively affect the delivery of equitable care and hinder effective communication.

Recommendations and opportunities

Firstly, to address the disparities in management roles, it’s essential to enhance training programs to provide managers with clear role divisions and effective direction. When employees have transparent communication from higher-up individuals, management can clearly define roles and delegate responsibilities to ensure accountability. This would aid in promoting communication and coordination between agencies because employees have a better understanding of whose responsibility it is to facilitate these interagency connections. Clear responsibilities also ensure consistent and comprehensive care delivery. Training to improve interagency coordination would encompass various aspects such as fostering cohesive teamwork, understanding how to appreciate each role and the expertise individuals bring, setting clear and understandable goals, and conducting community needs assessments applicable to all agencies

[63]. In addition, the improvement of this training would also help address the lack of case management and follow through, a weakness highlighted in Table 3. There also needs to be increased naloxone training, which could be easily facilitated by any agency but is a necessary task.

Moreover, technology training must be enhanced to equip providers with proficiency in using new platforms beyond conventional ones like email and phone. This training would vary depending on the type of technology platform, but general aspects could include ensuring basic computer skills and common software applications, internet and research navigation, understanding how to provide remote services, training employees on online communication tools and including specific aspects of new platforms. For example, in training for blockchain technology, in addition to the general aspects, employees would have to understand how to navigate large databases and how to upload new information.

Many care facilities need to be expanded to account for the increasing need for interagency communication. One recommendation to help facilitate coordination is the creation of co-locations that would have the space for multiple service providers. [64]. It is important to note that co-locations differ from community hubs in the sense that these would be solely dedicated to the service providers, whereas the other is often held in community centres that serve various purposes. Drawing from successful models observed in Australian communities, co-locations have proven effective, especially for mental health services in conjunction with other specialties. [65].

Regarding funding, while the need for increased resources is evident, concrete recommendations for obtaining additional financial resources were not found in this research.

Overall, these recommendations offer numerous advantages to the HKPR region. Firstly, enhanced training programs promise improved consistency in care delivery. By ensuring all employees possess standardized skills and practices across various domains such as technology and naloxone administration, agencies can deliver equitable care, thereby enhancing client health outcomes. In addition, more training would increase the number of employees who could deliver care, meaning agencies could take on more clients. The establishment of co-locations serves as another valuable asset, providing dedicated spaces for training and fostering interagency communication. These facilities not only support workforce development but also facilitate better coordination among agencies, ultimately enhancing the accessibility of care and facilitating transitions for clients.

Threats

Several barriers could impede the successful implementation of these recommendations. Primarily, there's a shortage of staff across various capacities, from recruitment to training. Without adequate staffing resources, enhancements may not be feasible. In addition, there are limited resources. Additionally, limited financial resources pose significant constraints, making it difficult to establish co-locations or hire additional staff. Ultimately, without the necessary human and financial resources, these recommendations face many difficult obstacles.

As a general recommendation to all disciplines of community-based care, it is imperative to assess the effectiveness and success of improvements by providing a method of evaluation. One resource that has been proven successful in the United States is the validated quality-of-life assessment tool which measures community satisfaction with healthcare by asking members various personal questions on various aspects of their lives [37]. This tool helps community leaders gather information from relevant populations to evaluate existing measures, develop new policies, enhance services, improve accessibility and improve care delivery [37]. Specifically, in the HKPR region this could help organizations evaluate services to determine if care is reasonably accessible, and communication efforts are effective.

Examining the insights gained from the focus group participants yields several noteworthy implications. In terms of providing more accessible care, home care and non-medical professional service models have been found to be successful in the HKPR region. However, there is an array of new service models that have been useful to communities in other Ontarian regions or other countries that if implemented, would likely benefit the HKPR region in providing more accessible and quality care with a warm handoff. In addition, identifying the various barriers faced by different clientele populations would help agencies provide more accessible care and warm handoffs by deciding what service model provides the best care to each group.

There is a pressing need to enhance overall interagency coordination, as it directly impacts the delivery of care and clients' experiences with community-based services. To address this, agencies should adopt a more cohesive approach to service provision, leveraging uniform committees, increased educational opportunities, and the establishment of service co-locations.

Furthermore, the integration of innovative technological platforms could significantly enhance coordination among agencies. Additionally, addressing training deficiencies, particularly in technology, interagency collaboration, and management, would further bolster agency coordination.

Although funding remains a significant challenge, better allocation of financial resources could significantly aid in the implementation of these recommendations. Despite the barriers that threaten their successful enactment, addressing these challenges through further research and strategic interventions holds promise for advancing community-based care on multiple fronts.

Limitations

This study encountered several limitations that warrant consideration. Primarily, the size of the focus groups was relatively small (N=23). Such limited group sizes can restrict the generalizability of findings, as they may not adequately represent the diversity within the broader population. Furthermore, smaller sample sizes diminish the statistical power of analyses, potentially compromising the ability to detect significant relationships or effects. Additionally, small group sizes are more susceptible to biases, which could introduce inaccuracies into the results. In this study, sampling bias was a concern, as participants were not anonymously recruited, potentially skewing the sample composition. Nonresponse bias was also observed, as some individual questionnaires were incomplete, potentially introducing further inaccuracies into the results. While efforts were made to mitigate these biases, its impact remains challenging to fully address.

Moreover, the lack of diversity within the participant pool may limit the representativeness of the findings. Although participants encompassed various roles and agencies, a significant proportion were affiliated with the same organizations. This may have led to a somewhat narrow range of perspectives, potentially overlooking important insights from diverse viewpoints.

Lastly, the study solely relied on the perspectives of service providers, overlooking the direct input of the populations receiving care. While service providers possess valuable insights into client needs, incorporating direct feedback from clients would have enriched the study's comprehensiveness and depth.

Future directions

Future research initiatives in community-based care enhancement hold significant promise for further advancing the understanding of this topic. To build upon the recommendations outlined in this study, researchers should investigate practical implementation strategies by examining the feasibility and effectiveness of the proposed interventions. By strategically aligning these recommendations with evidence and stakeholder perspectives, future studies can provide tangible improvements in community-based care provision.

Moreover, addressing the issue of funding scarcity is paramount for the successful execution of these recommendations. Future investigations could focus on identifying available funding sources and devising strategies to secure additional resources. These could help provide further efforts to increase care accessibility and interagency communication.

Lastly, it would greatly benefit future initiatives to hear directly from clients about ways to enhance community-based care and take into account this important perspective this research was lacking.

Conclusion

To conclude, the findings demonstrate the imperative need to address accessibility and communication gaps in community-based care to optimize client outcomes and experiences. Through a multifaceted approach consisting of literature reviews, service model assessments, and service provider focus groups, actionable recommendations have been created to enhance interagency coordination and ensure equitable access to care. Through SWOT analyses, this research has identified both successful aspects and areas for improvement in care provision and communication, along with opportunities and threats associated with the proposed recommendations, offering valuable insights for service providers on the current state and how to move forward.

From this research it is evident that the identified disparities in collaboration and accessibility pose significant challenges to client well-being, emphasizing the importance of implementing the suggested interventions. As a result, the recommendations propose enhancing current resource and service models, expanding education opportunities to improve communication and accessibility, strengthening existing structures and exploring new models to mitigate barriers faced by various populations. Moreover, promoting new technology platforms, improving current training methods (especially managerial) and securing additional funding are also proposed to further support these initiatives. The study found that these recommendations, if feasible, would greatly benefit communities in the HKPR region by increasing care accessibility and improving interagency communication, thereby increasing the quality-of-care provision overall.

When examining the findings, service providers will be able to gain a clear understanding of the strengths and weaknesses of their current practices, and how to proceed with them or fix certain aspects to be successful. Furthermore, the recommendations outlined in this report hold some promise for feasibility and effectiveness. However, many of these recommendations hinge on securing additional funding and financial resources, which currently pose challenges. As a result, while some improvements may be more readily achievable and successful than others.

By incorporating the findings of this research, community-based care practices can evolve into an even more effective alternative to primary care, ultimately advancing client outcomes and upholding the Canadian principle of equitable healthcare access.

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