implementing integrated Care for Older Adults with Complex Health needs: A Closer Look at Care First

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- Multi-disciplinary team of researchers and trainees
- Multiple perspectives from knowledge users (patients, family, policy makers)
In a nutshell

Our Question:

• What are the steps to implementing innovative Integrated Community Based Primary Health Care (ICBPHC) models that address health and social needs, and improve outcomes for older adults with complex care needs?

Outcome:

• This research program will develop a systematic guide to the design, implementation and scaling-up of innovative models of CBPHC.
Scale and Spread Care that Address Patient/Carer Values

**Policy Context**

**CONTEXT**
How ICBPHC is defined
Policy context
Timing

**Vision and Leadership**

**Activities (front-line providers)**

**Patient/ carer values**

**Scale and spread**
CHALLENGES

1. Relationships & trust supporting teamwork
2. Communication
3. Role clarity (working in scopes of practice)
4. Leadership style (e.g. hierarchy vs. distributed)
5. Strategic direction/vision (partnerships)
6. HHR and hiring practices

CARE COORDINATION

CONTEXT

Persons with complex care needs
Organization design
Co-location
Resource environment (funding)

Provider Activities- What Enables Provider Collaboration?
Vision and Leadership

• Leaders use the vision of **person-centredness** to:
  • Build partnerships and relationships within and across organizations
  • Encourage provider engagement
  • Drive practice change (particularly through distributive leadership)

• Common challenges
  • Information technology
  • Sustained resources (human and otherwise)
  • Ongoing provider engagement
Patients and Caregivers want to...

- feel heard, appreciated, and comfortable
- have someone they can count on
- understand how to manage health and what to expect
- be as independent as possible
- feel safe
- easily access health and social care
## Patients

<table>
<thead>
<tr>
<th></th>
<th>16 Patients Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>75% Greater than 75 years of age</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>81%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>50% Hong Kong</td>
</tr>
<tr>
<td></td>
<td>38% China</td>
</tr>
<tr>
<td></td>
<td>Majority immigrated to Canada &gt; 20 years</td>
</tr>
<tr>
<td><strong>Household</strong></td>
<td>44% lived with one other person (caregiver)</td>
</tr>
<tr>
<td><strong>Translated Interviews</strong></td>
<td>38% (Cantonese, Mandarin)</td>
</tr>
<tr>
<td><strong>Number of Conditions</strong></td>
<td>Average of 4 health conditions</td>
</tr>
<tr>
<td><strong>Mobility Impairments</strong></td>
<td>81%</td>
</tr>
<tr>
<td><strong>Anxiety/Depression</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>88%</td>
</tr>
<tr>
<td><strong>Unable to do usual activities</strong></td>
<td>75%</td>
</tr>
<tr>
<td><strong>Socioeconomic status</strong></td>
<td>19% not enough income</td>
</tr>
</tbody>
</table>
## Caregivers

<table>
<thead>
<tr>
<th>16 Caregivers Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>44% Ages 50 – 64</td>
</tr>
<tr>
<td>25% Ages 65 – 74</td>
</tr>
<tr>
<td>25% Age +75</td>
</tr>
<tr>
<td><strong>Female</strong></td>
</tr>
<tr>
<td>56%</td>
</tr>
<tr>
<td><strong>Country Born</strong></td>
</tr>
<tr>
<td>50% Hong Kong</td>
</tr>
<tr>
<td>31% China</td>
</tr>
<tr>
<td><strong>Relationship to Patient</strong></td>
</tr>
<tr>
<td>56% Child Caregiver</td>
</tr>
<tr>
<td>38% Spousal Caregiver</td>
</tr>
<tr>
<td>7% Friend/Volunteer</td>
</tr>
<tr>
<td><strong>Co-Residency with Patient</strong></td>
</tr>
<tr>
<td>87.5%</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
</tr>
<tr>
<td>19% Employed</td>
</tr>
<tr>
<td><strong>Socio-economic status (n = 15)</strong></td>
</tr>
<tr>
<td>53% Difficulty paying for things</td>
</tr>
<tr>
<td><strong>Health Conditions of Patients</strong></td>
</tr>
<tr>
<td>Average of 5 conditions</td>
</tr>
<tr>
<td>Mental Health (Depression, Alz/Dementia/Poor Memory), Hypertension, High Cholesterol, Diabetes</td>
</tr>
</tbody>
</table>
What it looks like when this need *is met*:

“But in the Carefirst, they speak Cantonese. So really sometimes really you can talk to them. But for the CCAC and for the other associations... I know this is Canada. Of course you have to speak English. But sometimes those important services, if they have someone who speaks Cantonese or Mandarin it would really help.” Caregiver 3

What it looks like when this need *is not met*:

“Because I know that what I see is the healthcare staff, they are very busy. So I don't want to tell them our personal stuff to increase their difficulties. I cannot tell them.” Caregiver 5
I have someone I can count on

What it looks like when this need *is met*:

“And about 3 weeks ago, I got up in the morning and by the time I got out here, I was so sick and everything was spinning... And the girls all came in that day... because I pushed the button to the cell phone...I pushed [case study provider] and they’ve been coming. They were all in here helping me out.” Patient 11

What it looks like when this need *is not met*:

“We can’t go anywhere. Like last Saturday, we had to hire somebody to watch her. Because there’s a flea market thing, and it’s only once a year. And my wife said, we’ve never been there, let’s go and look at it. It’s not sometimes easy to find somebody. You need somebody that you can trust.” Caregiver 27
I am able to be as independent as possible

What it looks like when this need *is met*:
“I’m just thinking if I live by myself, I would be very lonely. So I need somebody right here. With Carefirst, I can talk to people, we can do exercise together, we can eat together”. Patient 16

What it looks like when this need *is not met*:
“…And the other activity, meeting my friends. So yeah, so it’s really... Just like sometimes I would like to go out to have lunch or dinner with my friend. I can’t. So I have to watch him 24 hours.” Caregiver 3
I feel safe

What it looks like when this need **is met:**
“So right now she’s [homecare worker] on vacation. And we just hope maybe she can help that way. ... Like let’s say my mom doesn’t know those people. And people that you know, you feel more like safe...more secure.” Caregiver 27

What it looks like when this need **is not met:**
“My worry is because usually when I get to various doctors or specialist doctor, I will take the streetcar. And after getting off from the streetcar, I need to walk some distance to the clinic. And now my worry is because my memory is getting worse, I just worry that at some point, I may get off the streetcar and not remember how to go to the specific place.” Patient 7
I understand how to manage my health now and in the future

What it looks like when this need is met:
“They [providers] noticed his change. So the director called me and they asked the social worker to call me, and then she helped me and then called the [homecare agency] again and tell them. And she contacted the different departments about the dementia behaviour, and asked them to come for me to interview and to teach me how to handle his behaviour. “ Caregiver 3

What it looks like when this need is not met:
“Actually the doctor and the nurses are such busy people. I just tell them the symptom and they give me medication. That’s it....Nothing beyond the symptoms and the prescription.” Patient 9
I can easily access health and social care

What it looks like when this need is met:
“Like I can’t use my oven and stuff like that because I’m shaky. So that’s limited. The girls come in and help me. If I put something in the oven, I have to get them to come and take it out.” Patient 11

“They [Care First] helped me for over 2 decades. That’s why I can walk on my own. They help me with the shopping, like the milk, the bread. That’s why I can survive until now.” Patient 14

What it looks like when this need is not met:
“The doctor says if you go to Long Term Care facility], you have to pay a lot of money. If the government can provide us with a home for the old aged. You know, a small room even. We can go with the community, we can share everything.” Patient 16
Key Activities to Meet Patient and Caregiver Needs

The outcomes of importance identified in our research align well with the key tenets of *high quality, person centered care*

- With specific emphasis on the relational and social aspects of care

**Value Add:** We are able to describe specific activities that enable these outcomes of importance to be met.

At CareFirst: *key enabling features* were: *settings that offered multiple services* (day program, supportive housing); *language and communication support* (to support linkages to other services outside of Care First); *volunteers* (connecting and navigating services), etc.

**Emerging work by our team:**

- As we develop our implementation framework we will identify mechanisms at the policy, organizational, provider level that enable the outcomes that are important for patients and caregivers to be met.
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International Journal of Integrated Care

Special Collection
iCOACH. Implementing Integrated Care for Older Adults with Complex Health Needs

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