



Challenges and opportunities to integrating community care for older adults in rural communities

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Key needs of older adults- accentuated in rural locations

1. Integrated care for older adults
2. Family as team member and unit of care
3. Complex care needs such as frailty
4. Palliative approach to care



Integrated care for older adults

- ▶ Who is on the community care team?
 - ▶ Healthcare providers
 - ▶ Social services
 - ▶ Family
 - ▶ Community volunteers
- ▶ How is care coordinated or integrated?
 - ▶ Ways of integration-case management functions



Implementation science

- ▶ Evolved from evidence based practice and knowledge translation research
- ▶ Implementation science is defined as the scientific study of methods to promote the systematic uptake of research findings into routine practice (Eccles & Mittman 2006)
- ▶ The literature strongly advocates for the rigorous use of Implementation Science frameworks to guide the implementation of research findings (Nielson, 2015).
- ▶ Numerous frameworks can be used depending on the context

Eccles, M. P., & Mittman, B. S. (2006). Welcome to Implementation Science. *Implementation Science*, 1, 1.
<https://doi.org/10.1186/1748-5908-1-1>

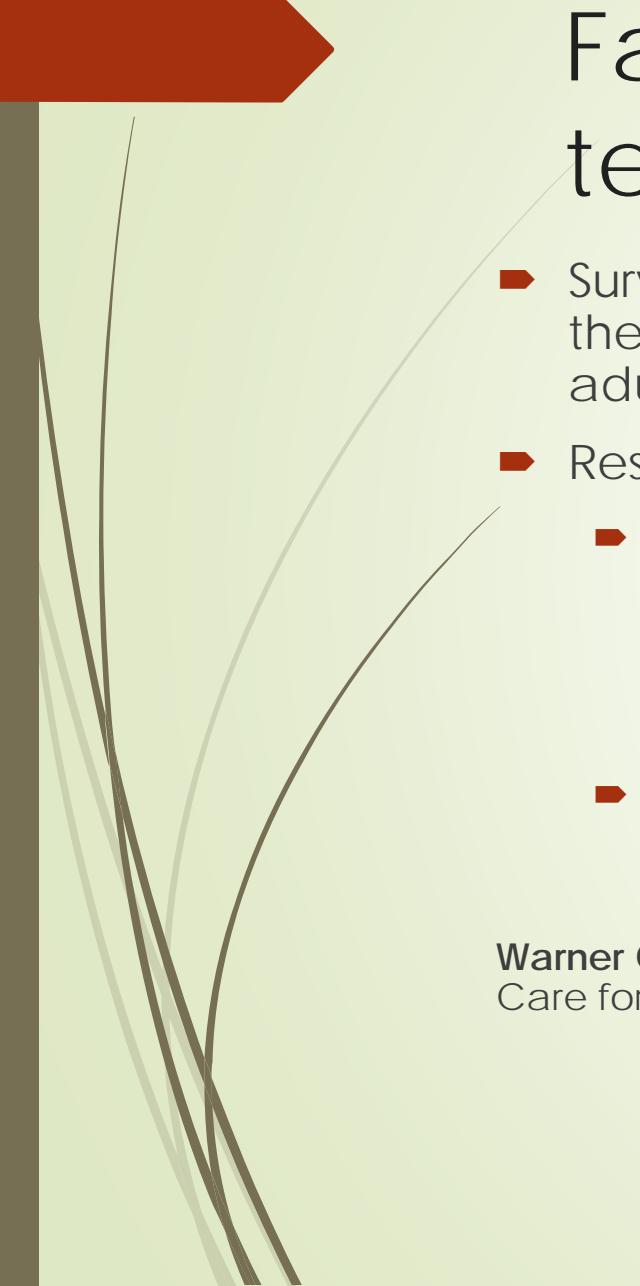
Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, 10(1).
<https://doi.org/10.1186/s13012-015-0242-0>



Integration of care between physicians, specialists and community services

- ▶ Qualitative study based on workshop delivered in rural health district.
 - ▶ Topic-implementing recommendations for secondary prevention of stroke.
 - ▶ Participants- family physicians, specialists and representatives from rural health district.
- ▶ Challenges:
 - ▶ Health authority difficulty involving physicians in upstream planning,
 - ▶ Family physicians fear referrals to community services may reduce continuity of care,
 - ▶ Rural family physicians have fewer opportunities for informal contact with specialists clustered in central locations this leads to poor communication, trust and coordination,
 - ▶ Family physicians lack of understanding of community services reduces referrals.
- ▶ Opportunities: workshop improved communication between participants

Warner, G., Harrold, J., Allen, M., & Lyons, R. (2010). Using a knowledge exchange workshop to uncover and address barriers to rural family physicians' applying secondary stroke prevention best practice recommendations. *Canadian Journal of Rural Medicine*, 15(4): 143-152.



Family as part of the care unit and team

- ▶ Survey and key informant interviews with rural community-based occupational therapists, their managers, and family/friend caregivers about services to older adults and their family caregivers
- ▶ Results
 - ▶ Therapists and managers: no formal restrictions on number of visits made to clients' homes, visits limited due to travel times and wait list pressures; family caregivers are critical to implementing therapists' care plans for client and motivating client; & important to refer to community resources. Most do not consider addressing the family member's needs is within their scope of practice
 - ▶ Family caregivers and support leaders: it is within therapists' scope of practice to educate family caregivers on how to care for the client, they want to be part of the team

Warner G., & Stadnyk R., (2014) What is the Evidence and Context for Implementing Family-Centered Care for Older Adults? *Physical and Occupational Therapy in Geriatrics*, 32(3): 255-270.

Complex care needs- Frailty

- ▶ Frailty is a physiologic syndrome; decreased reserve and resistance to stressors resulting from a cumulative decline across multiple physiologic systems (Fried & Walston, 2003).
- ▶ Nova Scotia Health Authority developed frailty strategy, within the strategy they created a web-based frailty assessment and care planning tool for primary health care practices called the Frailty Portal
- ▶ TVN funded research team assessed the challenges and supports to implement the Frailty Portal

Fried, LP & Walston J. (2003). Frailty and failure to thrive (1487 – 1502). In: Hazzard WR , Blass JP , Ettinger WH Jr , Halter JB , Ouslander J , eds. *Principles of Geriatric Medicine and Gerontology* , 5th ed. New York : McGraw-Hill.



Consolidated Framework for Implementation Research (CFIR) (Damschroder, 2009)

- ▶ Identified relevant theories then evaluated them based on strength of conceptual or empirical support.
- ▶ Consolidated constructs from 19 frameworks and models across various fields and disciplines (e.g. dissemination, innovation, organizational change, implementation, knowledge translation, and research uptake)
- ▶ Created overarching taxonomy for framework for understanding the implementation of new knowledge across multiple levels of the healthcare system
- ▶ Systematic review has now looked at how the CFIR has been used (Kirk, 2016)

Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implement Sci* [Internet]. 2009; Aug 7;4:50. doi: 10.1186/1748-5908-4-50.

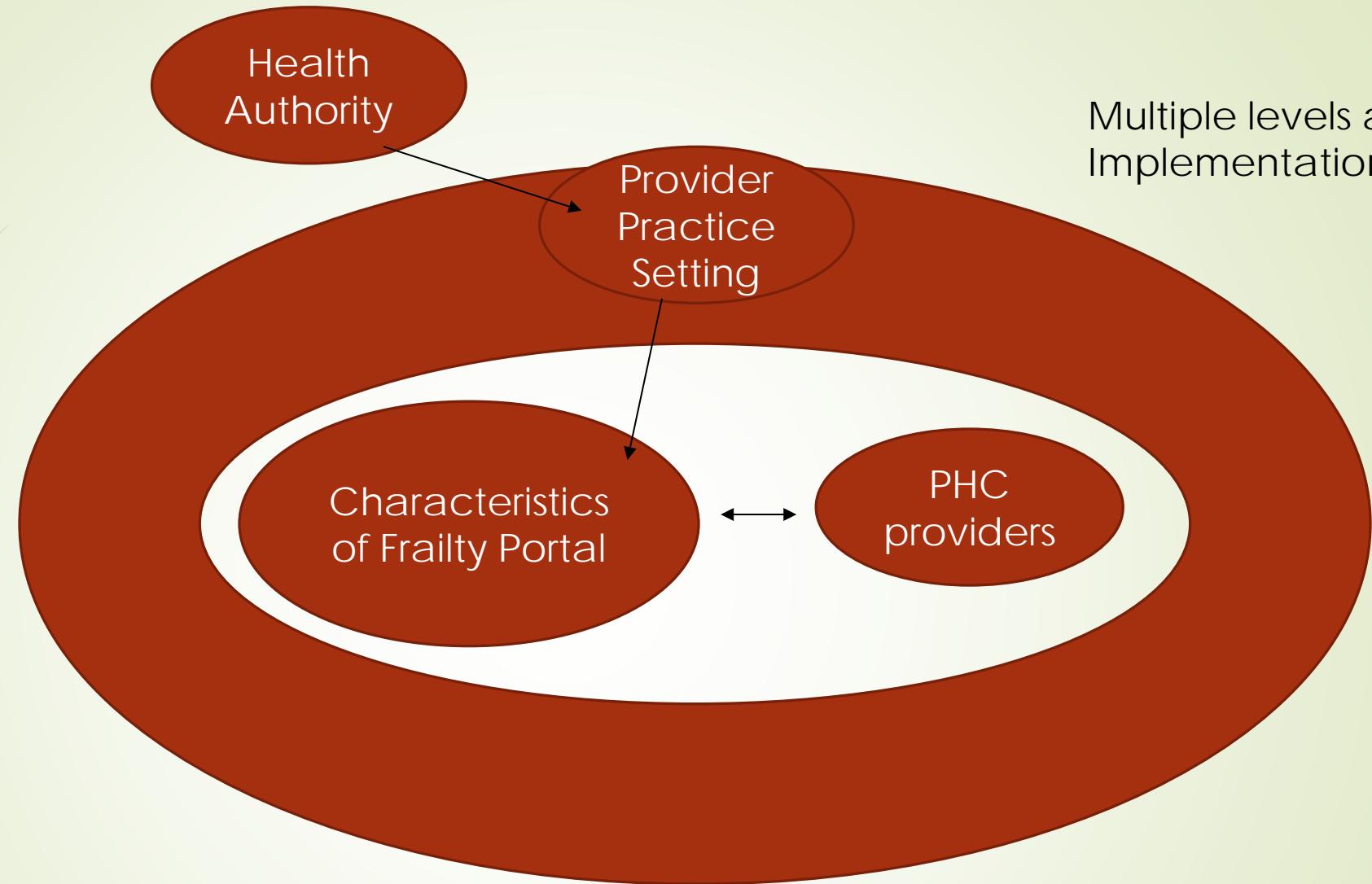
Kirk, M. A., Kelley, C., Yankey, N., Birken, S. A., Abadie, B., & Damschroder, L. (2016). A systematic review of the use of the Consolidated Framework for Implementation Research. *Implementation Science*, 11(1), 72



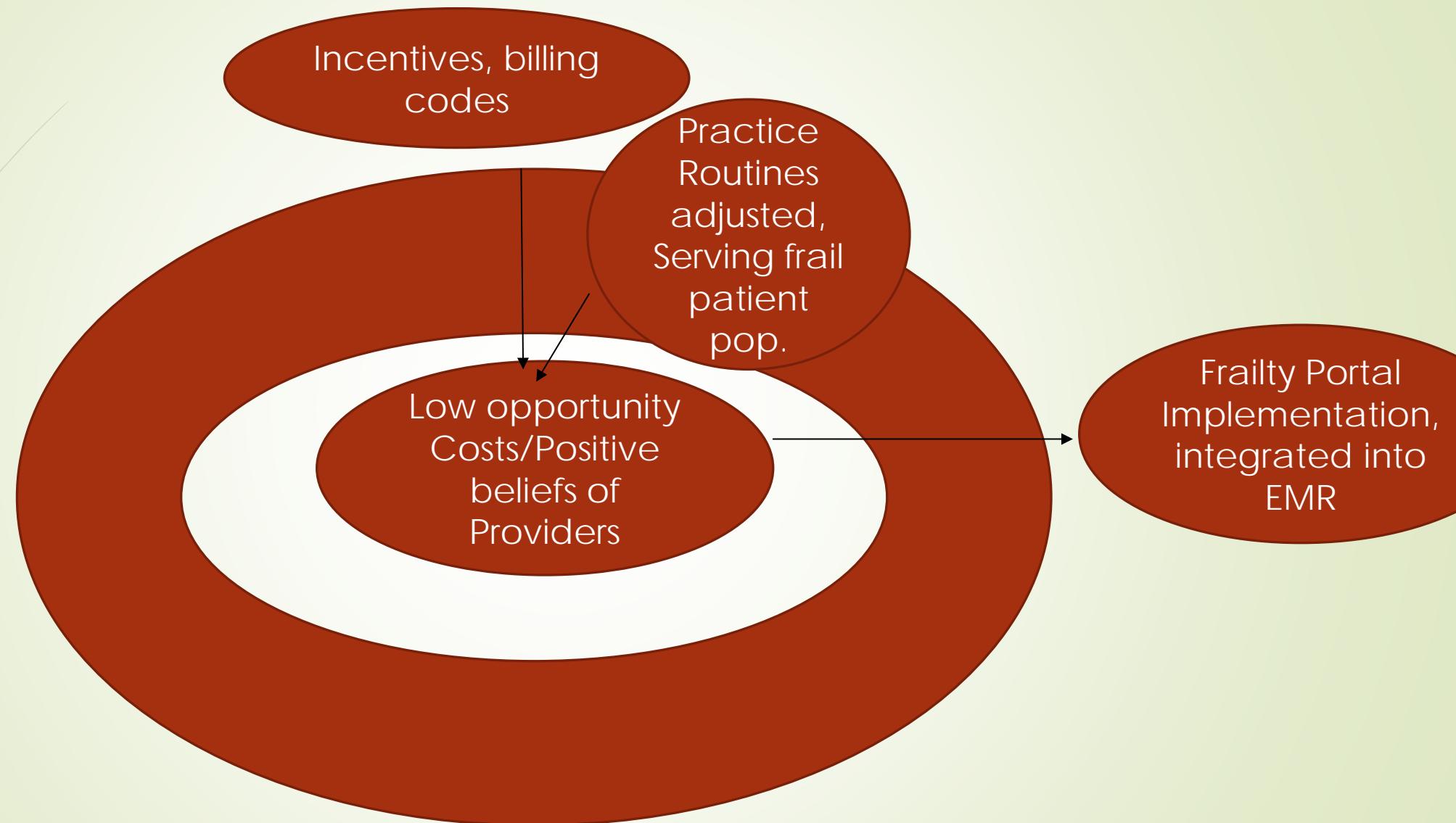
Background- CFIR

- ▶ Thirty-nine constructs organized into five major domains found to influence the successful implementation of innovative programs.
- ▶ The domains assess
 1. Intervention characteristics (eight constructs)- Frailty Portal
 2. Outer setting (four constructs)-Health Authority
 3. Inner setting (12 constructs)-Primary Care Practices
 4. Characteristics of individuals (five constructs)- Primary Care Providers
 5. Process (eight constructs)-Process of implementing Frailty Portal

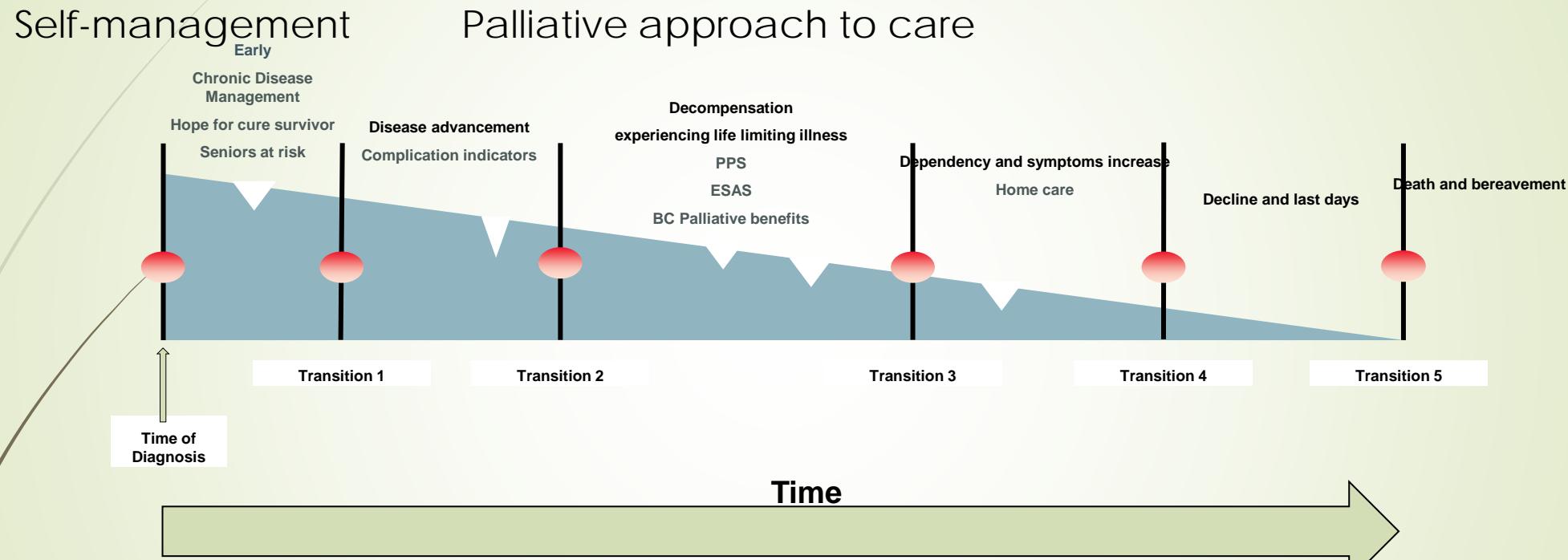
Multiple levels affect Implementation



Sampalli T, Lawson B, Wood S, Warner G, Moorhouse P, Gibson R, Mallory L, Bedford L. (2017) Evaluating the Implementation and Feasibility of a Web-Based Tool to Support Timely Identification and Care for the Frail Population in Primary Healthcare Settings. *International Journal of Health Policy and Management*, 6(7), 377-382. Doi: 10.15171/ijhpm.2017.32



Palliative Approach to care: curative to palliative Care through all the transitions



McGregor and Porterfield 2009



Novel Approach to integrating care-volunteers as part of the team

- ▶ Navigating Connecting Accessing Resourcing Engaging (**NCARE**)-training hospice volunteers to assist those with serious illness and their families, to facilitate the transition from curative to palliative.

Duggleby, W., Pesut, B., Cottrell, L., Friesen, L., Sullivan, K., & **Warner, G.** Development, implementation, and evaluation of a curriculum to prepare volunteer navigators to support older persons living with serious illness. Accepted by the American Journal of Hospice and Palliative Medicine October 10, 2017.

Pesut B, Duggleby W, **Warner G**, Fassbender, K, Antifeau, E., Hooper, B., Gerig, M., & Sullivan, K. (2017) Volunteer navigation partnerships: Piloting a compassionate community approach to early palliative care. *BBC Palliative Care*, 17(2),1-11.



NCARE Findings

- ▶ Benefits for older adults and their families:
 - ▶ Increased confidence in being able to ask for help, having someone knowledgeable and available, knowing there was backup when needed, helping put things into context, and bringing awareness of available resources
- ▶ Challenges for volunteers:
 - ▶ Volunteers unsure about role expectations, contributions to care, and how to measure performance

Integrative Review: challenges to volunteers working with healthcare providers

- ▶ Issues with Volunteer and healthcare provider relationships
 - ▶ Lack of role clarification can create tension
 - ▶ Different knowledge and view of palliative care can result in lower referrals from health care professions to volunteers
 - ▶ Volunteers need to understand the larger palliative care system
- ▶ Unique challenges in rural areas
 - ▶ Problems with patient confidentiality when everyone knows everyone

Connell B, Warner G, Weeks L. (2016) The feasibility of creating partnerships between palliative care volunteers and healthcare providers to support rural frail older adults and their families: An integrative review. American Journal of Hospice and Palliative Medicine. Available electronically at:
<http://ajh.sagepub.com/content/early/2016/07/19/1049909116660517.full.pdf?ijkey=liuwwsvxvNe1lua&keytype>



Conclusions: challenges to integration

- ▶ Provider
 - ▶ Knowledge and awareness of other services
 - ▶ Confidence in care provided by others
 - ▶ Scope of practice may not include families
 - ▶ High opportunity costs for implementing innovative practices
- ▶ Rural
 - ▶ Distances between providers and clients/patients
 - ▶ Less density leads to lower access to care and less contact between family practitioners and specialists
 - ▶ Solo family practices- less support for implementing innovative practices

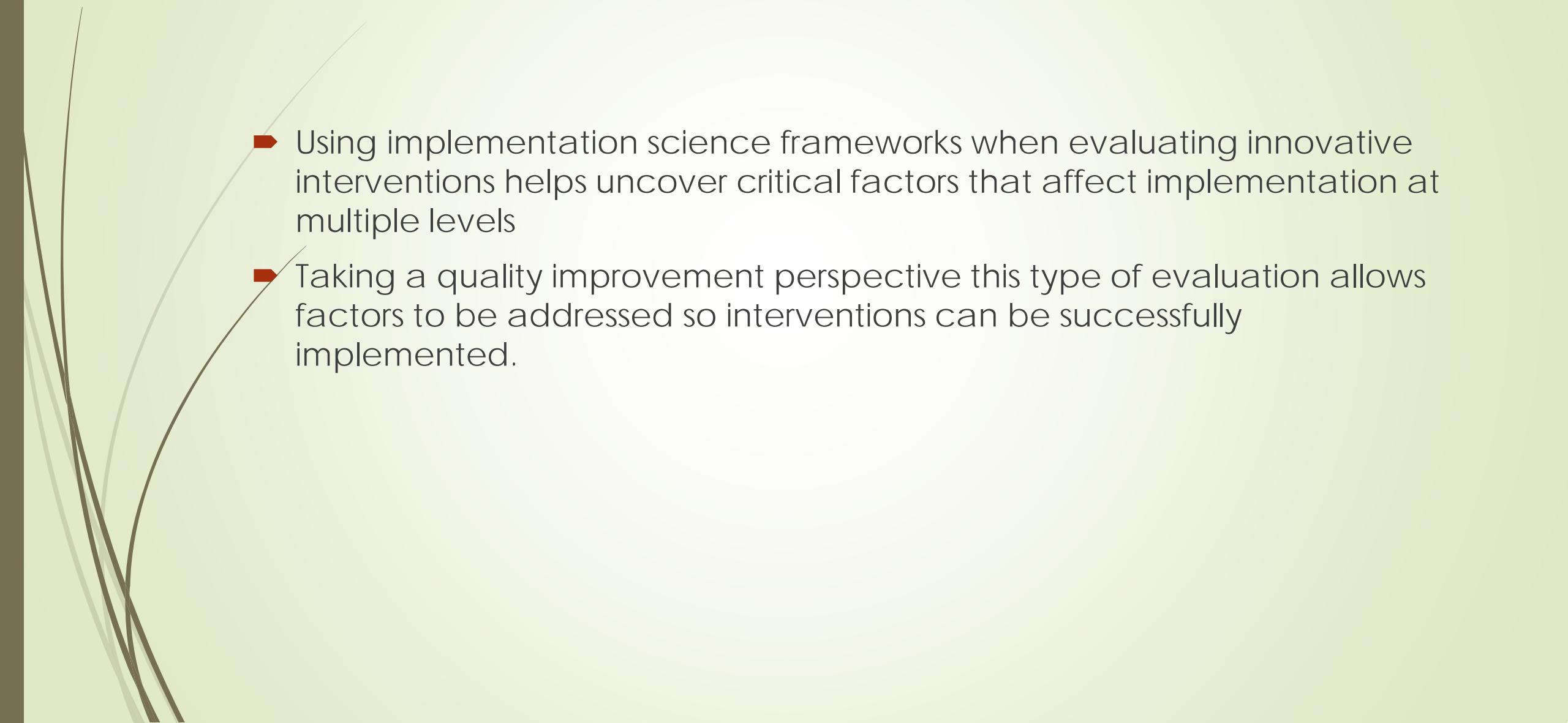
Conclusions: Opportunities

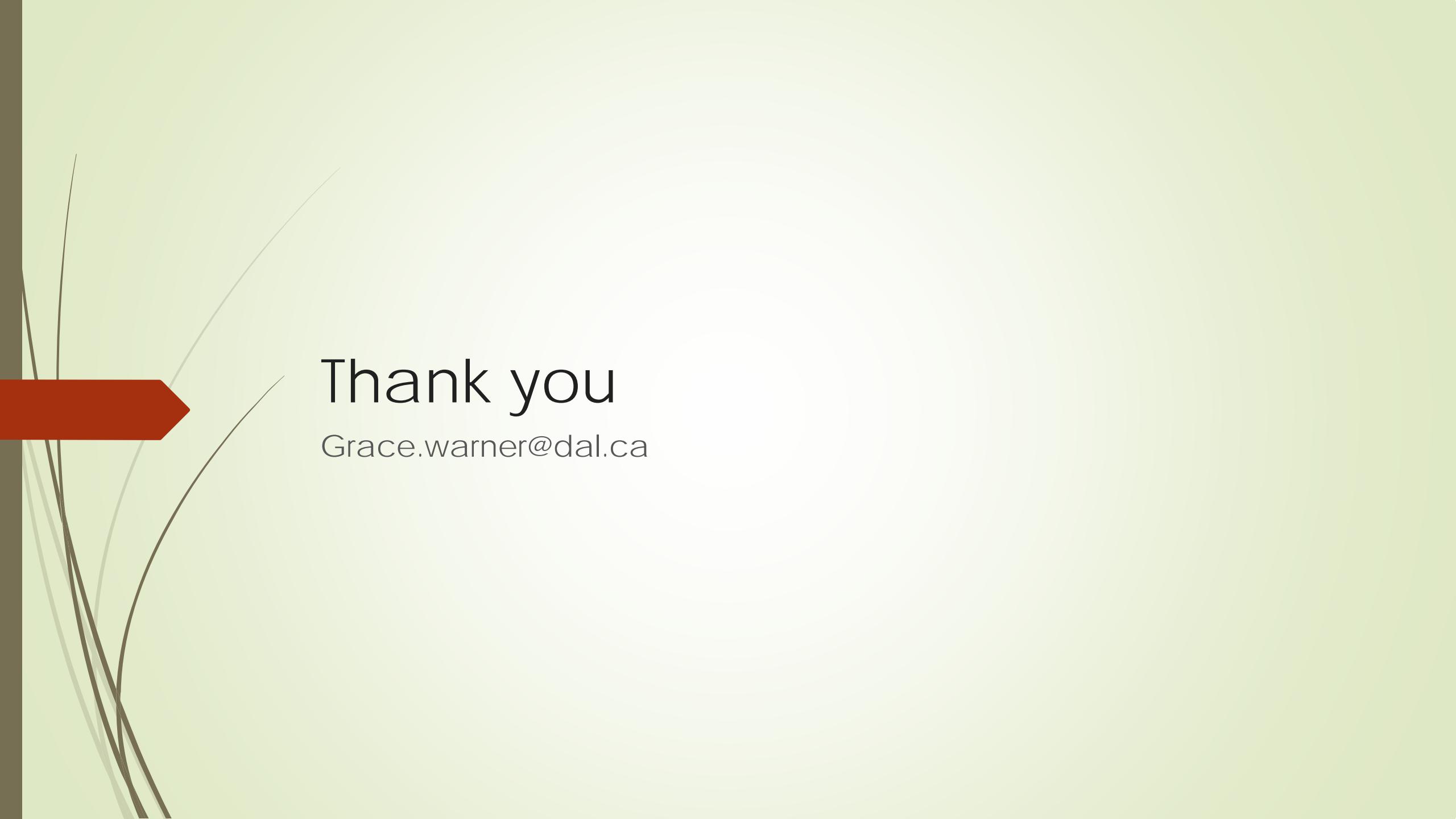
- ▶ Collaborative care teams (interdisciplinary) are being implemented in more rural locations
- ▶ Community services can provide psychosocial supports and education to enhance self-management strategies for individuals and their families
- ▶ Volunteer capacity in communities may provide opportunities to improve psychosocial supports
- ▶ Learnings from the palliative approach to care could apply to other scenarios such as frailty
- ▶ Case Management is “a collaborative, client and family caregiver centred process for the provision of quality health and support services through the effective and efficient use of formal and informal health and social resources”. Implementing case management functions could improve integration

National Case Management Network (2012). Canadian Core Competency Profile for case Management Providers. Retrieved from: <http://www.ncmn.ca/>



Conclusion: Recommendation

- ▶ Using implementation science frameworks when evaluating innovative interventions helps uncover critical factors that affect implementation at multiple levels
 - ▶ Taking a quality improvement perspective this type of evaluation allows factors to be addressed so interventions can be successfully implemented.
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Thank you

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