

“It makes you feel more like a person than a patient”  
Findings from patients receiving home-based primary care  
(IHBPC) services in Toronto, Ontario

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# Agenda

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- Introduction
- Project Overview
- Research Design
- Findings
- Discussion
- Conclusion

# Learning Outcomes

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After this session, participants will be able to:

- Identify current models adopting the integrated home-based primary care (IHBPC) model in Toronto, Ontario
- Describe key themes from qualitative data exploring patients' experiences and perspectives receiving IHBPC
- Outline the advantages and challenges of using telemedicine with the frail older adult population

# Project Partners

6 Academic FHTs, House Calls, Toronto Central CCAC



*Taddle Creek*  
Family Health Team



**MOUNT SINAI HOSPITAL**  
Joseph and Wolf Lebovic Health Complex

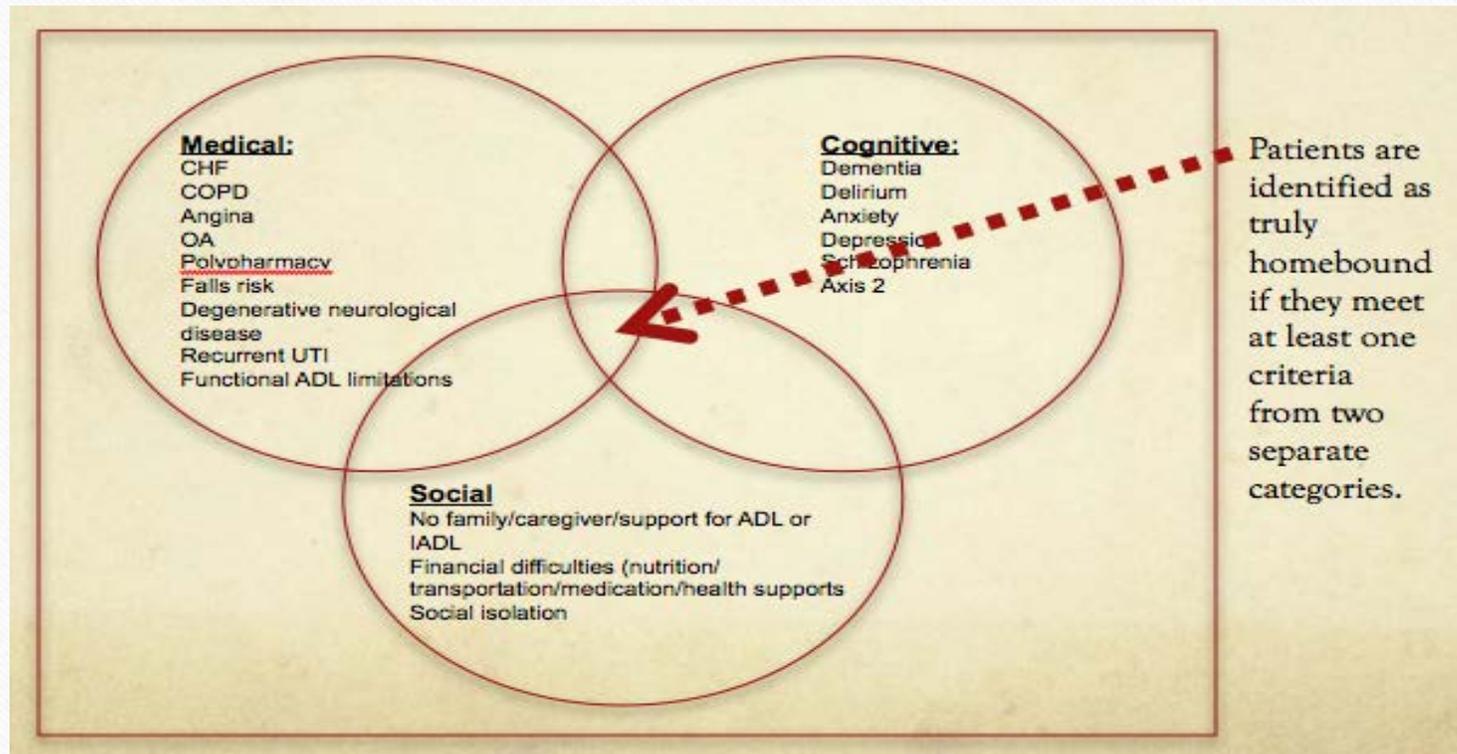


*South East Toronto*  
Family Health Team

**St. Michael's**  
Inspired Care.  
Inspiring Science.



# Who are our patients?



# Project Objectives

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## Patient Care Objectives

**Provide a comprehensive** and integrated approach to patient and client care

**Improve transitions in care** between acute, primary care and community care settings

**Establish a network** of specialists to support home-based primary care

## Integrated Care Team Objectives

**Develop shared understanding** of roles, responsibilities and accountabilities between providers

**Improve communication** among team members and across the continuum of care and organizations

**Enhance care management partnerships** between primary care and community care providers

## Research Objectives

Investigate the health outcomes and system benefits for IHBPC

# IHBPC Study Objectives

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The IHBPC model brings together hospital, specialist, and primary & community care professionals together to improve the care of one of our most vulnerable & marginalized patient populations: frail older adults

The IHBPC study involves mixed methods research to investigate the effectiveness of IHBPC and the experiences of patients, families and health care providers with this model of care

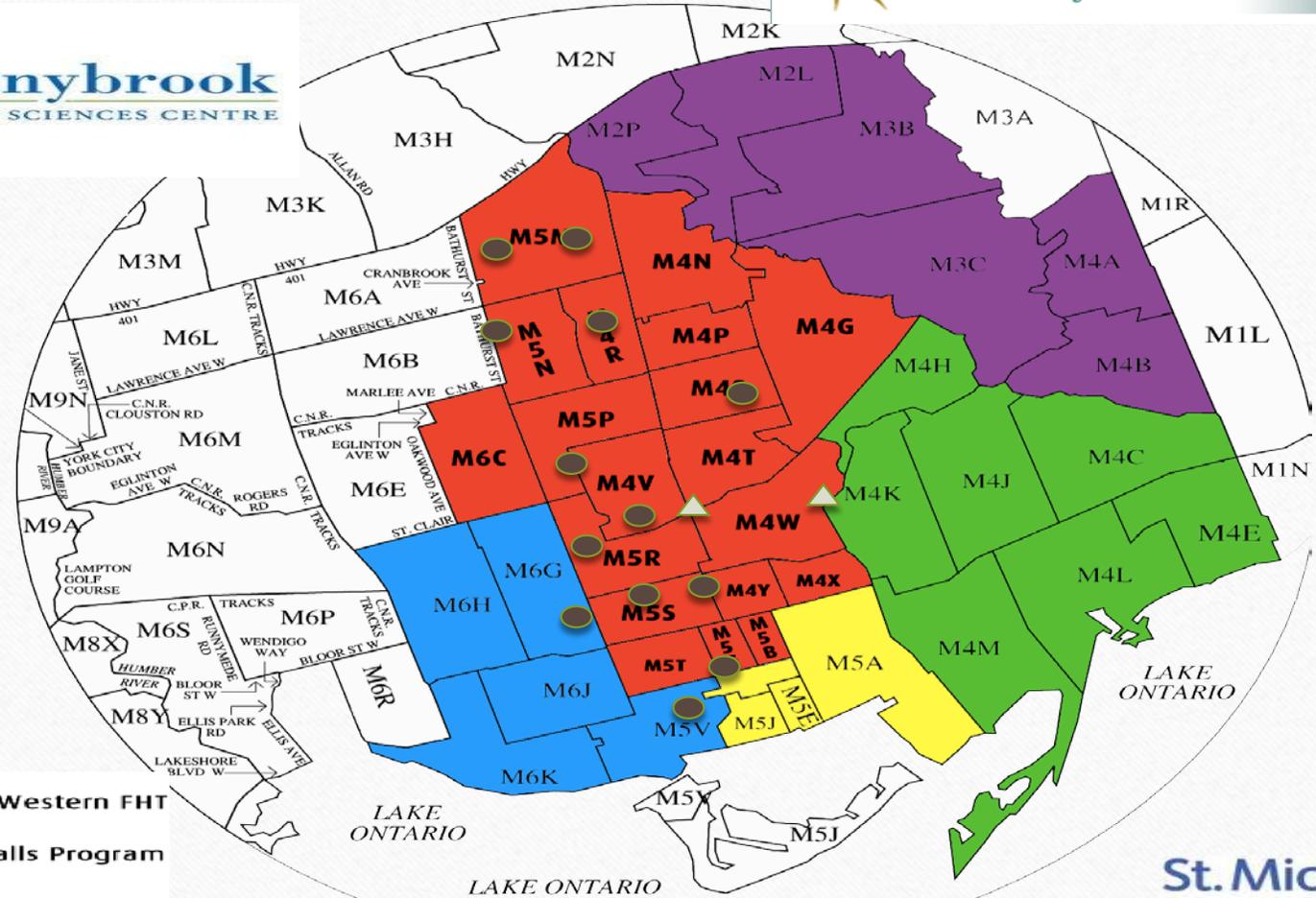
The qualitative research aims to explore patients', caregivers', team members' and key stakeholders' experiences with IHBPC, & their perspectives on the facilitators and barriers to this model of care

# Integrated Home Based Primary Care Catchment



Taddle Creek FHT

- South East FHT
- St. Michael's FHT
- House Calls Program
- Sunnybrook FHT
- Toronto Western FHT
- MSH FHT



# Patient Site Totals

\*Totals as of February 20, 2014

Site	Current Total	# of Patients Consented for PHI Collection	Active Patients
Mount Sinai Hospital	16	9	6
SMH	30	22	20
SETFHT	61	48	32
Sunnybrook	57	44	27
Taddle Creek	59	28	48
TWH	69	31	51
SPRINT	410	261	221
*TOTAL	672	423	405

# Research Components

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## *Qualitative Analysis*

Interviews with four sample groups:

- Patients
- Caregivers
- Team Members
- External Stakeholders

# Research Components (continued)

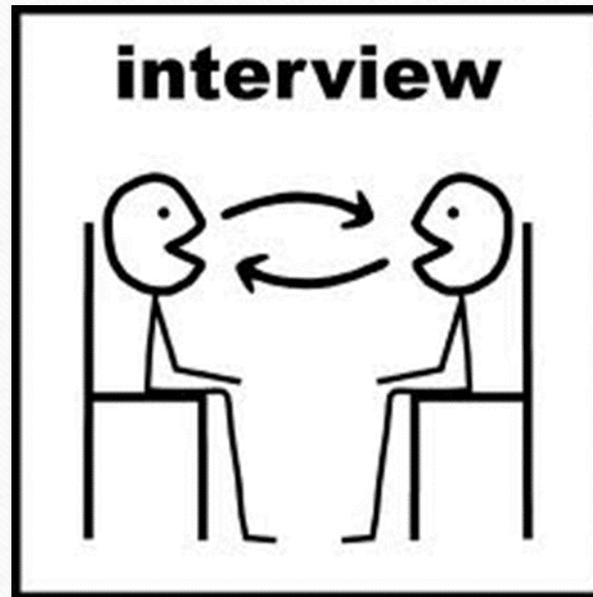
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## *Quantitative Research and Economic Analysis (with AHRC, St. Michael's Hospital)*

- Analysis of hospitalizations, ED visits, etc. using ICES data
- An economic analysis to understand the differences between usual care and IHBPC

# Qualitative Research

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# Research Questions

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## *Explored:*

- What are patients' perceptions of IHBPC?
- What are patients' experiences with this model of care?
- How do these experiences compare to their experiences with the usual approach to care (office-based care)?

# Research Design

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- 6 FHTs + 1 IHBPC CSS team = 7 sites in Toronto
- Interviews undertaken winter of 2013
- Grounded theory methodology
- Recruitment through circle of care (professional recruitment strategy; Hogan, Loft, Power, & Schikin, 2009)

# Research Design (continued)

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- Semi-structured one-hour in-person interviews
- Topic guide was followed
- All interviews (n=26) were transcribed verbatim & reviewed, memos kept
- Data analyzed using NVivo (v. 10)

# Inclusion Criteria

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- Older adults age 65+
- Demonstrated difficulty accessing office-based primary care
- Not living in a retirement/nursing home facility
- Not palliative at time of enrollment
- Living in the team's catchment area
- Willing to transfer responsibility of primary care to team

# Data Analysis

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- First round of open coding to discover key categories & dimensions
- Coding was iterative; axial coding refined categories into themes
- To ensure rigour - regular peer debriefing among 4 researchers; inter reliability measurements ( $\kappa = 0.92$ )

# Necessity of IHBPC

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## *Patients Subject to Inadequate Primary & Social Care Without IHBPC*

- IHBPC is “not a luxury, (but a) necessity.”
- “It’s not a question of like or dislike. It’s a question of answering an extreme need, (I’m) not able to go out, not able to walk as far as my kitchen.”
- “Well, I’ve had anxiety all my life...agoraphobia...so I don’t go out of the house very much. I’m afraid to go away from the home you know.”

# Compared to Office-Based Care

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## *Difficult to get to office – limited mobility*

“It’s not a question of like or dislike. It’s a question of answering an extreme need, (I’m) not able to go out, not able to walk as far as my kitchen.”

## *Difficult to get to office – expense of taxis*

“...(A)nd after I started (to get) sick, and I spend a lot, a lot of money with taxi...”

## *Difficulty at the office*

“In the office you always have to wait because (there are so) many people.”

# Compared to Office-Based Care (continued)

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## *Perceptions: Increased ER visits*

“Oh I’d just go to emergency. I never want to go there (the doctor’s office) again to be honest.”

## *Perceptions: Risk to patient and others*

“If you’ve got bronchitis, or as I had this last time, pneumonia, in (the) winter, it isn’t good to be going outside and it isn’t very good to be waiting in the waiting room infecting all the patients.”

# Benefits of IHBPC

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## *More Time and Attention*

“I never have the feeling that (the provider) is rushed or that I’m being short changed where time is concerned.”

## *Relationships*

“Well, it’s nice to know that you’ve got a support system, and I have one of my own (the team), which is pretty good, and we have a lot of fun.”

# Benefits of IHBPC (continued)

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## *Communication*

“The communication has been very, very, very clear.”

## *Length and Frequency of Visits*

“... (S)/he listens to my heart, we talk at some length about what might be of concern to me. . .”

“(I)f something would happen if I would call I would see someone probably within 24 hours.”

# Benefits of IHBPC (continued)

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## *Perceived Higher Quality of Care*

“Convenient and they do seem to have a more specific interest in my personal situation, in my personal medical situation than I might expect in an office visit.”

## *Intimate Environment*

“Well, it’s more personal, isn’t it? They come to the house, have a coffee or tea or some fruit or something.”

# Quality of Life

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## *Perceived Health Status*

“No, my health cannot improve much because I know they cannot do anything for that (the condition).”

## *Sadness Surrounding Limitations*

“My life is not bad. The problem is I can't go out...I have a walker; I think I used it once outside, and I just went around the corner, I couldn't go further...I think it would help my heart to walk.”

# Quality of Life (continued)

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## *Loneliness*

“I don’t go out the door sometimes for days and days at a time. . .Yeah, I get lonely sometimes.”

## *Anxiety/ Depression*

“Naturally you have moments of depression and anxiety, and anxiety about the future for your children, and the problems that they have. Not that I can do that much, but I’m still here.”

# Feelings Surrounding IHBPC

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## *Feelings/Emotions*

“Well, knowing that somebody cares, knowing that there is a doctor, that there are services that I can access. . . makes me feel comfortable.”

“It’s a feeling of relief...I think s/he’s an excellent doctor, and I began to feel secure with him/her... a feeling of relief that I would have someone who could monitor it (the condition).”

“It took the fear away of how you were feeling, knowing full well that someone was looking after (you).”

# Patient Satisfaction

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## *No Expectations*

“Well really to be honest I didn’t have any expectations.”

## *Exceeded Expectations*

“Makes you feel more like a person than a patient.”

“They treat me like I have money.”

“Sometimes I think I’m the Queen... the Queen don’t do (sic) better than me...that they come to my house...that they treat me good. I have everything I need.”

# Patient Satisfaction (continued)

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## *Positive Feedback*

“I think it’s a wonderful program.”

“It really is fantastic.”

## *Grateful for Program*

“That is very helpful. I’m very grateful.”

“Yes, I like it. It’s certainly good care and I am very thankful for it.”

## *Would Recommend to Others*

“Yeah, well I would certainly recommend it, and I would approve of it being extended because I think it means that people get better care.”

# Barriers

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## *Environmental Contamination*

“People come in off the street and they don’t wipe their feet and the dirt that comes in here...this is my bedroom and they walk right in and I can’t stand up and clean it myself.”

## *Lack of Privacy*

“The only think I have to criticize about the program is you lose...and this happens when you’re ill I’ve found out...you lose any privacy you ever had...so that can be very stressful.”

# Improvements to IHBPC

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## *Need to Expand Program*

“I can tell you it must be much larger than it is, much larger.”

## *Greater Access to Physicians*

“But if you ask me how it could be improved that would be...if more often, not every time, more often I could talk directly with the doctor.”

Themes from Patient Data

Topic Guide Subject	Parent Nodes	Child Nodes
Patient Care Prior to Enrolment	Issues with office-based care	Wait times, difficult due to limited mobility, cost of transportation, difficulty accessing transportation, reliant on a caregiver, difficulty hearing/seeing/reading
	Feelings/emotions associated with office-based care	Stress, anxiety, fear (agoraphobia), strain, fatigue
	How patient managed care before HBPC Who turned to for advice	Hospital/ED, family physician, alone, caregiver Family physician/nurse, ED, telehealth, clinic
Patient Experience of HBPC	Perceived higher quality of care/patient centred care	Personal interest in my care, constant monitoring, patient involved in care plan, accessibility, convenience
	Intimate/comfortable environment	Comfort of home, intimate
	Communication	Listens to me, explains information
	Relationships	Support system
	Coordination/integration of care	Value of team approach, other home care services, arranged by patient/caregiver
Patient Satisfaction	Length and frequency of visits	Never rushed/more time, frequent visits
	Feelings/emotions associated with HBPC	Reduced fear, relief, security, peace of mind, confidence
	Expectations entering HBPC program Expectations met while in HBPC program	No expectations Met expectations, exceeded expectations
	Overall satisfaction of service	Positive comments, grateful/thankful, would recommend program
Quality of Life	Health status	Same, worse, improving
	Experiences of anxiety/depression	Anxiety, depression
	Loneliness	Homebound
Barriers to HBPC	Invasion of space	Lack of privacy, environmental contamination
What would change about HBPC	Items to change	More funding, need for mental health services, more time with physician, guidance on exercise

# DISCUSSION



# Discussion: Improved Health Outcomes

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- High burden of illness associated with this population (Olsan et al., 2009) makes achievement of significant long-term improvements in patient health uncertain (Mayo et al., 2014) – equivocal health outcomes for HBPC (Hughes et al., 2000)
- De Jonge et al.'s (2014) study found no statistically significant difference in survival times between HBPC patients & matched non-HBPC controls

# Discussion: Better Access to Care

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## *Why?*

- HBPC in Indiana had, as a result of newly acquired access to care, new diagnoses after enrolment (difficulty walking, cognitive impairments & depression; Beck et al., 2009)
- Improved access to primary care is associated with greater service utilization (Beck et al., 2009) & services for patients with MCCs can be expensive (Lehnert et al., 2011)

## *And yet...*

- Access to ongoing primary care lowers ED use (Ionescu-Ittu et al., 2007)
- And cost of home & community care services less expensive than hospital & other institutionalized care alternatives (North et al., 2008)

# Discussion: Business Case

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- De Jonge et al. (2014) found significantly lower costs for HBPC patients in Washington, DC as compared to a matched control group, with greatest savings realized by older adults in the frailest sub-group
- HBPC presents a solid business case by promoting greater savings to the health care system (through preventing avoidable ED visits and hospitalizations)
- More than business case – patients with complex care needs prefer – and need – this model of care – here’s why...

# Patients' Quality of Life

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# Discussion: Quality of Life

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- QoL often conceived of as a global (perceived life satisfaction/wellbeing; Hellstrom & Hallberg, 2001) or health-related measure (HRQoL) assessing physical & mental health status; Barile et al. 2013)
- Chen et al. (2011) found those with MCCs reported worse HRQoL than those with none/one chronic condition, & as # of MCCs grew, so too did frequent physical distress
- Borg et al. (2005) - QoL among older adults with reduced self-care capacity determined by social, physical, mental & financial aspects (self-reported health status, having sufficient funds to meet one's needs, limitations in performing ADLs, feeling worried & loneliness)

# Discussion: Quality of Life (continued)

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- Isolation (homebound), lacking adequate social interaction - more prone to depression (Choi & McDougall, 2007)
- Social isolation is a significant predictor of re-hospitalization for socially isolated older American veterans (Mistry et al., 2001)
- Our study, HBPC team might be only source of social support

# Discussion: Quality of Life (continued)

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- Strong patient-physician relationships associated with medication adherence (Wroth & Pathman, 2006), & patients with high trust in their providers can have improved outcomes, particularly in chronic disease management (Murray & McCrone, 2014)
- Consequently, home visits may be particularly helpful in meeting social needs; increasing QoL

# Discussion: Patient-Centered Care

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- Patient-centered care is that is “respectful of and responsive to individual patient preferences, needs, & values, & ensur(es) that patient values guide all clinical decisions” (IOM, 2001, p. 3)
- Many patients highlighted the relational aspects promoted through this model, receiving HBPC “*makes you feel more like a person, than a patient*”
- Being known as an individual (a marker of patient-centered care; Hanyok et al. 2012) is optimized

# Discussion: Patient Satisfaction

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- Expectations influence satisfaction, but how these are defined, & the ways they are measured, typically vary (Bowling et al., 2012)
- Patient satisfaction in our study data was not linked to a priori expectations (*“I had no idea how it would work. I figured they’d help me...”*)
- Albeit not expressly vocalized, expectations were fulfilled, & satisfaction amplified, as patients experienced HBPC by a team of specialists trained in medical & social care in an ongoing (connected, coherent continuity of care), timely & relationship-centred manner

# Discussion: Patient Satisfaction

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- The majority of patients, in our study and others, are highly satisfied with team-managed HBPC care (Beck et al., 2009; Cooper et al., 2007; Hughes et al., 2000)
- The ‘peace of mind’, ‘sense of security’ and ‘relief’ associated with receiving HBPC in our study are echoed in findings by Muramatsu et al. (2004)
- HBPC patients can remain in their homes where they prefer to live and HBPC can facilitate a death at home (De Jonge 2008; Rosenberg 2012), where most prefer to die (Brazil et al. 2005)

# Conclusion

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## *HBPC*

- Ensures appropriate care for a highly vulnerable population
- Improved quality of life
- Better patient satisfaction
- Provides patient-centred care

*Thank you!*

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