Supporting Caregivers across the Care Continuum

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Learning Objectives

- Understand the important role family caregivers play across the care continuum
- Understand caregivers support needs and how they change across the care continuum
- Consider a model of caregiver support and mechanisms for intervention delivery
- Understand factors that influence caregiver program implementation
5 Yeung EH, Szeto A, Richardson D, Lai SH, Lim E, Cameron JI. The experiences and needs of Chinese-Canadian stroke survivors and family caregivers as they re-integrate into the community. Health Soc Care Community 2015 Sep;23(5):523-31.
Our Starting Point

- Families have needs beyond medical care post-stroke
- These needs change across the illness trajectory
Language Disclaimer

“Caregiver”

- Family member, friend, neighbour or other individual(s) who provides assistance to someone who is unable to fully care for themselves due to illness
- Not financially compensated
- Can also be “carer”, “care partner”, “support network”, “informal caregiver”
“Louise”

Acute Care:

- “It was a blur” “It all seemed so fast”~ emergency department. Not respected or supported. Overwhelming. Need to understand what happened and what is next. “Panicked” about discharge home.

Rehabilitation:

- Staff were great! Supportive! Support from family too! Help with IADLS
“Louise”

Preparing for home:

- “I was not prepared”! “Panicked”! Need emotional preparation. Need written instructions.

First at home:

- Needed respite to do IADLs, time for self.
“Louise”

Now:

- Minimal family support. Ignoring husband with communication difficulties. Extreme emotional upset for both. Future not as planned. MANY emotions
- Trying to re-engage in social activities, exercise programs, volunteer activities
- Future is uncertain, decline expected
Why Care for Caregivers?

- 1 in 4 Canadians are caregivers (~9.1 Million, 2016)
- Support stroke survivor recovery, rehabilitation, and community reintegration
- Saving health care system $60 billion/year (Fast, 2018)
- US over $450 billion/year (Feinberg, 2011)
- Many experience stress, burden, poor mental health, quality of life, disrupted life, work, etc...
  ~ can ultimately impact patient outcomes
- Not standard clinical practice to prepare caregivers
Canadian Best Practices

- Education
  - Addressing patients and caregivers’ needs for education

- Transitions
  - Supporting patients and caregivers as patients transition across care environments

- Emerging role of the Navigator
Social Support Context
(Cohen, 1992)
Stroke Trajectory
Does it come down to Timing?

Family Caregivers:
“the information book was too much in the hospital”
“the information was excellent once home”

Stroke Survivors:
“when we left the hospital, the door closed and there was no more information”

Health Care Professionals:
“it is difficult to know when patients and caregivers are ready for information”
“Timing It Right” Framework

- Comprehensive five-phased approach to support families from the hospital to the home
- Emphasizes the timing of support needs across the care continuum
- **Premise**: addressing phase-specific needs will enhance family preparedness, ease transitions across care environments, and minimize negative outcomes (e.g., burden)

TIR Phases

1. Event/diagnosis
2. Stabilization
3. Preparation
4. Implementation
5. Adaptation

\{ Acute Care
\{ Acute/Rehab
\{ Home

Stroke families’ have different support needs across these phases
The good news...

- “Educational content should be specific to the phase of care or recovery across the continuum of stroke care and appropriate to patient, family and caregiver readiness and needs [Evidence Level B]. (Cameron & Gignac, 2008)”

Sources of Support
Support Mediums

https://www.youtube.com/watch?v=qCBIn470bIM
Support Mediums

How does the use of different mediums change across the illness trajectory?

- Limited research available

People:

- Support from family/friends tends to decrease over time
- Support from HCPs also decreases over time
- Peers of more interest in the community
TIR Changing Needs

- Informed by qualitative interviews
  - Health care professionals
  - Caregivers
  - Patients
  - Various studies
## Event/Diagnosis

<table>
<thead>
<tr>
<th>Support Needed</th>
<th>Source of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information: diagnostic testing, treatment, medications</td>
<td>Health care professionals</td>
</tr>
<tr>
<td>Emotional: sense of being cared for</td>
<td>Family/friends</td>
</tr>
<tr>
<td>Instrumental: comforts, form completion, companionship, parking, accommodation, help at home</td>
<td>Health care professionals and family/friends</td>
</tr>
<tr>
<td>Training: none</td>
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The nurses and the doctors there, they did keep us well informed of what was going on and what the care would become and how they would switch the medications... which kind of put our mind at ease. *Rehab Caregiver, husband*
you need just someone to prop you up and tell you it’s going to be okay, or you know things are going maybe be different. But not to get into a great detail with you then, you just need some moral support then. Emotional support. *Aphasia Caregiver, wife*
Event/diagnosis – Tangible Supports

Everybody was very nice... they would get me a chair so I could stay, asked me if I needed a coffee or something or a blanket. *Rehab Caregiver, husband*
## Stabilization

<table>
<thead>
<tr>
<th>Support Needed</th>
<th>Source of Support</th>
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<tbody>
<tr>
<td>Information: what is a stroke, medical status, expected recovery, rehabilitation eligibility and options, care processes, roles of HCPS</td>
<td>Health care professionals</td>
</tr>
<tr>
<td>Emotional: sense of being cared for</td>
<td>Family/friends</td>
</tr>
<tr>
<td>Instrumental: comforts, form completion, companionship, parking, accommodation, help at home, transfers between hospitals, arranging rehabilitation</td>
<td>Health care professionals and family/friends</td>
</tr>
<tr>
<td>Training: support ADLs in hospital</td>
<td>Health care professionals</td>
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“Then, only a couple of days ago, a nurse just happened to be there when my Mom was getting out of bed. So she showed me the easier way for my mother to get out of bed… the easier way to get her out of the wheelchair… so I would have appreciated knowing all that, at the beginning… – because I spend a lot of time here – if somebody had taken the trouble to say, “Look, we can see that you’re helping your Mom. This is like the basic things that she’s doing on a regular basis during the day, this is how to do them.” I think it would have definitely benefited me and my Mother… because I would have been doing the things.” Daughter, caregiver
## Preparation

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<th>Support Needed</th>
<th>Source of Support</th>
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<tbody>
<tr>
<td>Information: care plan, rehabilitation goals and intensity, home care services, secondary prevention, navigating the health care system</td>
<td>Health care professionals Peers</td>
</tr>
<tr>
<td>Emotional: more relaxed and optimistic</td>
<td>Family/friends</td>
</tr>
<tr>
<td>Instrumental: participate in rehab, discharge planning, disability insurance application, community care service planning, accessing ongoing rehab, ensuring home safety, coordination of f-u appts, someone asking how caregiver is doing</td>
<td>Health care professionals Family/friends</td>
</tr>
<tr>
<td>Training: mobility, transfers, medical care at home, rehab exercises, proving home care, manage behaviour changes and depression, weekend passes</td>
<td>Health care professionals</td>
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Interviewer: Did they teach you anything as you prepared to go home?
Caregiver: Not really, not a lot and I guess because I wasn’t there everyday at that point and the days that I was, I could go and watch him (in therapy). But that was about it.
*Rural Caregiver, wife*
## Implementation

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<th>Support Needed</th>
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<tr>
<td>Information: secondary prevention, where to go with questions, how to care and support rehabilitation at home, realistic expectations regarding outpatient therapy and recovery, community reintegration, community-based programs/services to support caregiver</td>
<td>Health care professionals Peers</td>
</tr>
<tr>
<td>Emotional: sense of being cared for, sharing experience with peers</td>
<td>Family/friends Peers</td>
</tr>
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</table>
Support Needed | Source of Support
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Instrumental: case manager, home safety, more home care services based on needs of survivor and caregiver, respite care, day programs, assistance at home, follow-up call from in-patient HCP to check on survivor and caregiver, person to contact with questions, visits from family and friends, organize long-term care papers | Health care professionals and family/friends
Training: managing rehabilitation at home, communication (aphasia), stroke survivor mental health, support community reintegration, managing the unexpected (e.g. problem solving skills) | Health care professionals
Appraisal: need for feedback on their care-giving skills | Health care professionals
My needs were “Tell me that I’m doing things right.” And that’s what I didn’t get. *Aphasia*
*Caregiver, wife*
## Adaptation

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<th>Support Needed</th>
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<tr>
<td>Information: communication, stroke affects the whole family, life after stroke, community reintegration, preventing or coping with future health events, long-term care options, caregiver respite opportunities</td>
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<tr>
<td>Emotional: emotional comfort, sense caregiver is being cared for</td>
<td>Peers</td>
</tr>
<tr>
<td>Instrumental: re-assessment for community and rehabilitation services, need for supports received during implementation to continue, respite, peer support groups</td>
<td>Note: Health care professional support not evident Family/friend support decreases over time</td>
</tr>
<tr>
<td>Training: communication, prevention of future events, learning to live with the chronicity of stroke</td>
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... refresher course, refresher appointments... but if there were some way of having smaller groups with ongoing once a year training.

*Aphasia caregiver, wife*
Interviewer: What do you think about when you think to the future?
Caregiver: I’m very frightened because, I’ve watched... the last little while you can see him going downhill. I wonder constantly when another one is going to happen. My own well being. Just last week, I was to the doctor and I have high blood pressure now. *Rural Caregiver, wife*
How do we tie all this together to support stroke families across the care continuum?
One possibility: The Timing it Right Stroke Family Support Program
Intervention Development

- TIR framework provided outline
  - One “chapter” for each TIR phase
  - Consider informational, emotional, tangible and training needs
- Qualitative study (Cameron et al, 2013)
  - 24 family caregivers (15 aphasia), urban and rural,
  - 14 health care professionals, across care continuum
- Leveraged existing educational resources
- Developed new material as needed
- Interdisciplinary review committee
- Reviewed and revised for local context
TIMING IT RIGHT

STROKE FAMILY SUPPORT PROGRAM

TORONTO EDITION

Table of Contents

Chapter 1..................................................................................Introduction

Chapter 2...............................................................................My Family Member Has Had A Stroke

Chapter 3..............................................................................My Family Member’s Condition Has Stabilized

Chapter 4............................................................................Preparing To Go Home

Chapter 5...............................................................................The First Few Months at Home

Chapter 6..............................................................................Getting On With Life In The Community

Chapter 7..................................................................................Notes And Additional Resources
How do you deliver support across care environments?

- Qualitative study (Cameron, et al, 2013)
  - “one person to provide support”
  - “follow-up after we have left the hospital”

- What have others done?
  - Telephone support (e.g., Grant, 1999, 2002)
  - Trained nurses (e.g., van den Heuvel, 2002)
  - Family Support Organizers (e.g., Lincoln, 2003)
  - Models of Integrated Service Delivery
    - Case management (PRISMA ~ Hebert, 2003)

- Stroke Support Person (SSP) – one key individual, in person during acute care, by telephone thereafter.
Stroke Support Person

- Health Care Professional
  - Occupational Therapist
  - Nurse
  - Social Worker
  - Other

- Expertise in stroke management and care options
- Trained volunteer?
Key Roles of SSP

For each session:

1. Emotional Support
   - Ask “how are you doing?”

2. Informational Support (Intervention Guide)

3. Tangible Assistance and Guidance
   - *Navigate* to appropriate resources, community services

4. Appraisal - Feedback on how they are managing
   - “it sounds like you are managing well”

Note: SSP does NOT replace existing services but helps families connect to services
Giving stroke families the support they need when they need it!

_Pilot study:_ Cameron et al Clinical Rehab, 2014

_ProtoCol:_ Cameron et al, BMC Health Services Research 2014
Knowledge Translation Study (V. Tseung)

Key Informant (n=12) and Qualitative descriptive (n=73) studies with knowledge-users – Ontario Stroke Network

1. A deeper understanding of caregivers and the importance of implementing caregiver programs is warranted.
2. Evidence supporting the value of a caregiver program is essential.
3. Stakeholder engagement is important.
4. Incorporating caregiver education and support into clinical practice is complex.
Questions

- What can you take from this to your own practice?
- Population?
- Care environment?
- What is in place to support families?
- How does the navigator role support families?
Take home messages

- Support is multi-dimensional
- Support needs change across illness trajectory
- Many sources and mediums of support
- “Timing it Right Stroke Family Support Program” is one model to address changing needs
- “Timing” is the lens
Thank you!
Questions?
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