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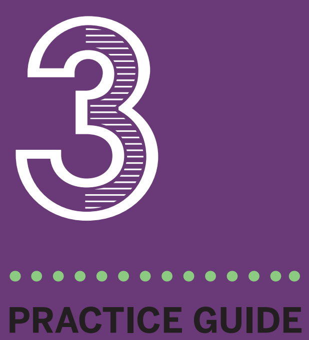

PRACTICE GUIDE

How can patient and caregiver needs be met by PROVIDERS & MANAGERS?

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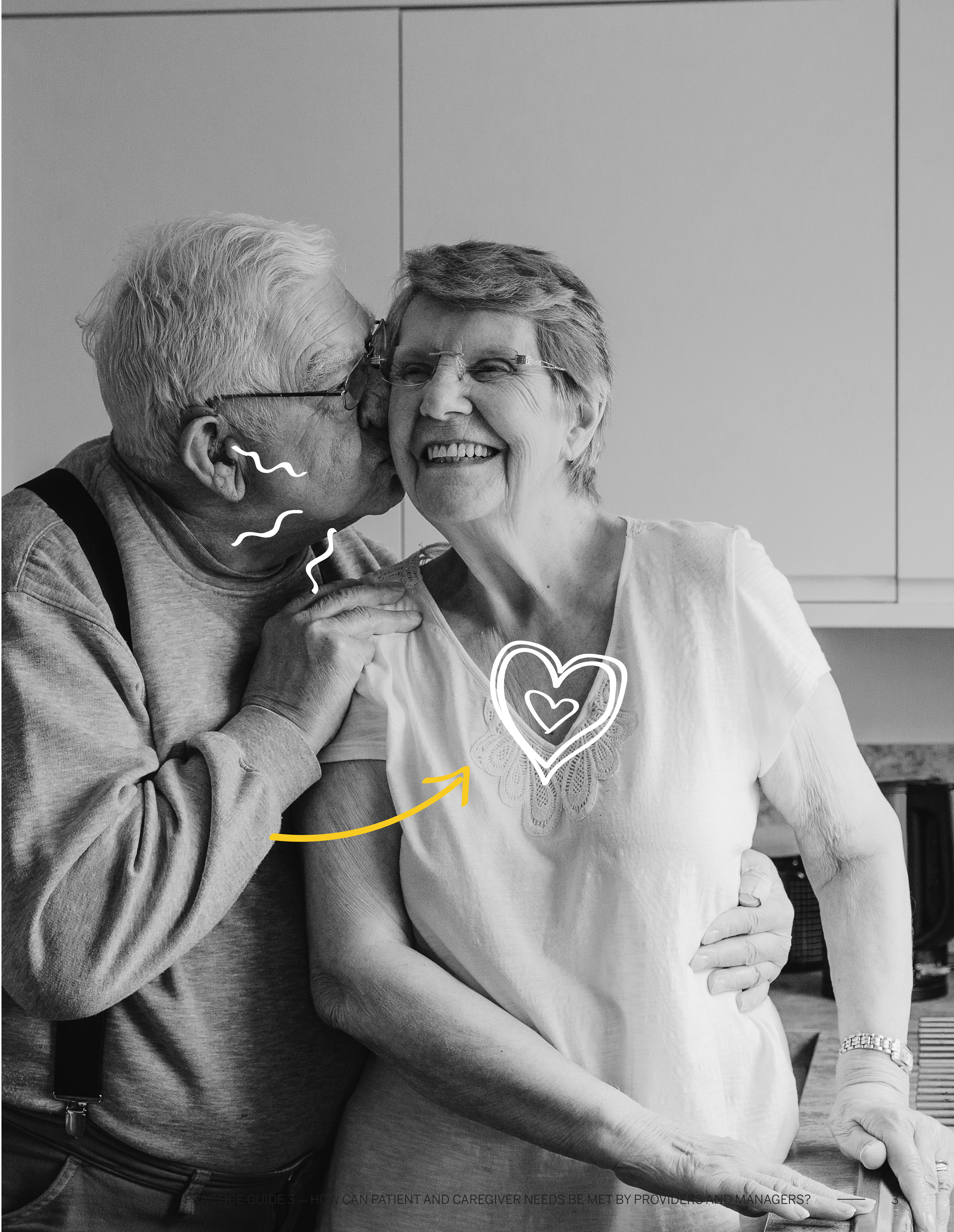


FOREWORD

Four practice guides for Ontario Health Teams

Four practice guides were prepared for Ontario Health Teams (OHTs). The guides are relevant for any group of providers and organizations aiming to implement a connected health care system centred around patients, families and caregivers. Each of the four guides focuses on a different aspect of a more connected and better integrated approach to care and has a slightly different emphasis and target audience. The guides can be read independently but achieving the overall implementation of OHTs will require attention to all dimensions presented.

This is the third guide which focuses on the activities of providers and managers that are necessary to achieve patient and family/caregiver-centred care. The activities are organized around the 6 attributes and specific vignettes are provided that demonstrate what providers and managers have to do to enable the well-organized system in contrast to the fragmented case. The audience for this guide is primarily providers and managers though it is relevant to senior leadership that need to create the context that enables providers and managers to focus on these new activities and to create the space and time required for change.

The first guide focuses on essential aspects of implementation. It outlines key activities that are necessary at the organizational and inter-organization levels and activities required of senior management across organizations in order to enable managers and providers to reorganize around patient and family/caregiver-centred care. The implementation of OHTs will not be successful unless organizations think differently about care and set parameters so that providers and managers realign their care to think across organizational lines to encompass the patient's journey. The primary audience for this guide is organizational leadership.

The second guide focuses on what it means for care to be centred around patients, families and caregivers and highlights 6 essential attributes of patient and family/caregiver-centred care. Two case vignettes are presented that characterize when a care system is well organized around a patient, and when the care system is fragmented. Achieving the well-coordinated system is a common thread that runs through all of the guides with specific mention in 3. This guide is central to the overall focus of Ontario Health Teams and is relevant to all leaders, providers, patients and the public.

The fourth guide focuses on governance. This guide outlines the internal and external changes that have to occur to create sustainable systems of connected care. The audience for this guide is organizational leadership and governors.

While there are many important aspects to implementing integrated care, this starter set provides a basis for understanding important new ways of working and fundamental shifts in collaboration across health and social care providers. Many more topics are important including population-based management, co-design, human resources and workforce transformation to name just a few. The most important guidance is to retain a focus on what is important to patients and caregivers; gather together the people you need to work with; agree to a common vision and principles that support your planning and implementation work; and build and support trusting relationships with all your team members. These essential ingredients, blended with courageous action, will accelerate your success.

3 PRACTICE GUIDE SUMMARY

How can patient and caregiver needs be met by providers and managers?

In this practice guide, we present the activities done by providers and managers working in integrated care models and discuss how these meet patient and caregiver needs.

What activities are done by providers and managers in integrated care?

We present 32 activities done by providers and managers working in integrated models of care. We distinguish the activities as occurring on either the front-stage or back-stage of care delivery:

1/ Provider front-stage activities involve interactions between providers and patients

2/ Provider back-stage activities involve interactions between providers

3/ Manager front-stage activities involve interactions with staff and patients

4/ Manager back-stage activities involve interactions with other managers and stakeholders

We illustrate how these activities are interrelated, with the success of some relying on the presence of others. Importantly, we show how providers and managers will require diverse skill sets (including both technical and relational skills) in order to engage in both front-stage and back-stage activities.

The presented interconnected activities can be used as a starting point for Ontario Health Teams, but these should be co-designed to fit local contexts and regularly monitored through the implementation process to ensure they are helping meet patient and caregiver needs.

What are the 3 key takeaways?

1

Identify what activities you are already doing across partners at both the front-stage and back-stage and see where there are gaps. Think about how activities are interconnected and co-dependent. Components already in place may require adaptation and modification to align with an integrated model with network partners.

When building teams of providers and managers, think about the diverse skill sets needed to be able to engage in both front-stage and back-stage activities. Often both clinical and relational skills will be required to be successful in both front-stage and back-stage roles.

The 32 activities of providers and managers can, and should, be adapted to local contexts through co-designing with providers, patients and families.

INTRODUCTION

Why this is important

Once committed to the vision of delivering more integrated health and social care services to meet the needs of patients and families, the next step is determine what front-line staff and management teams will actually do make it a reality.

A recent scoping review found that models of integrated care include a number of key components including: person-centredness, holistic or needs assessment, integration and coordination of services, collaboration, and self-management (Struckman et al., 2018). These components can be achieved through different activities that providers and managers engage in every day as part of the delivery of care. However, research in the field of integrated care has demonstrated that it is not simply about putting a new set of processes in place, but about understanding how these processes interact with one another and work within different contexts to achieve desired outcomes (Shaw et al., 2018; Kirst et al., 2017; Vargas et al., 2015).

This guide uncovers the activities of front-line providers and managers working in integrated care models; discussing what these activities look like, how they're different from how you may have been working before, and, perhaps most importantly, how these activities are linked and related to each other. For the purposes of this guide, the term providers refers to clinical and point-of-care staff (physicians, nurses, social workers, therapists, care coordinators, physician assistants, volunteers, and reception/clerical staff) that interface directly with patients and caregivers to deliver health and social care services. The term managers refers to administrative staff that support, guide and lead operational processes (administrators, IT support, quality improvement staff, managers, directors). The two Mrs. Lee case vignettes are used to illustrate how front-stage and back-stage activities can lead to each of these two scenarios.

But first, a quick self-assessment...

Collaboration. How well does your organization connect and collaborate with other programs and organizations in the community?

Not well — Very well

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Coordination. How well does your organization coordinate service delivery for patients and their families across programs and organizations in the community?

Not well — Very well

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Self-Management. How well does your organization support self-management of patients and families?

Not well — Very well

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How this relates to Ontario Health Teams

Ontario Health Teams (OHTs) will be tasked with providing a "full and comprehensive continuum of care at maturity" (MOHLTC, 2019). This will require redesigning care pathways that encompass a full continuum of care within and across organizational partners, with an aim to establishing care teams that will be responsible for delivering services across that continuum.

OHTs can use this practice guide to identify activities that care teams and managers engage in when delivering integrated care. Importantly, this document will help OHTs to: 1) identify the more obvious front-facing activities of care delivery they will need to engage in (e.g., setting up a care plan), as well as the less obvious; and 2) link front-facing activities to less obvious back-end processes and managerial support activities (e.g., building a supportive and collaborative culture) required for those care teams to be successful.

INSIGHTS

Meeting patient and caregiver needs through provider and managerial activities: Lessons from the literature and iCOACH study

The accompanying patient and caregiver practice guide summarized 6 attributes of the care experience that matter most to patients and caregivers. Taking these attributes as a starting point (representing the desired outcomes of patients and their families), we link practical activities of providers and managers that support these attributes. To identify these activities, we engaged in: 1) a targeted literature review identifying existing reviews of key activities of integrated care; 2) a symposium session with managers and providers who deliver integrated care services to review and discuss the value of these activities; and 3) comparing the findings of the literature review to data from the iCOACH study. This strategy yielded a list of 32 activities of providers and managers delivering integrated care for older adult patients.

Notably, these activities overlap with the critical success factors identified in the accompanying practice guide on implementation, demonstrating that some of the factors can and should be achieved through the activities of both managers and providers. This connection between success factors and the provider and manager activities of care delivery further demonstrates the importance of collaborative leadership approaches as successful implementation is contingent on the work of leaders driving the change, as well as the activities of providers and managers engaging in the change.

The list of 32 activities emphasizes the day-to-day work and processes that providers and managers will need to engage in to support an integrated model of care. Some of these activities are more obvious and explicit in the delivery of integrated care and play a front-facing role; for instance, in-taking new patients or creating a care plan with an inter-professional team. However, what the iCOACH study (Shaw et al., 2018) and other research on integrated models has shown is that these activities can only be successful if other processes or activities are in place in the back-end (Kirst et al., 2017; Vargas et al., 2015; Ling et al., 2012). For example, creating environments that support strong relationship building between providers is critical to help support professionals to work effectively as a team (Karam et al., 2018).

Front-stage and back-stage activities

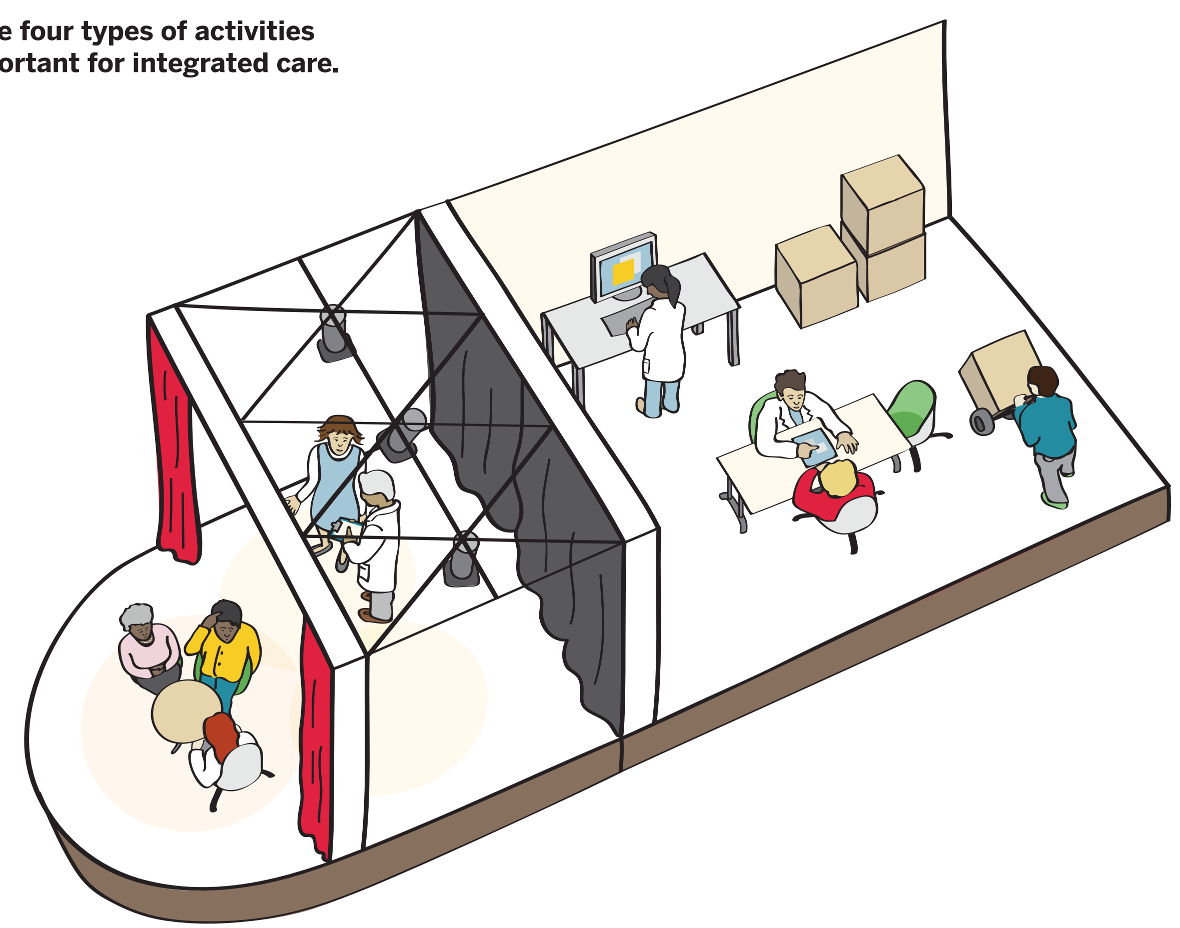
To unpack these multiple-layers and inter-relationships, we use the analogy of front-stage and back-stage to describe the types of activities required of providers and managers to realize integrated care. This is not to suggest that one layer of activity is more important than another, but rather to bring to light how the layers interact, and require that providers and managers play multiple, and sometimes new, roles to engage in these different types of activities. Understanding these roles more clearly can help in assigning tasks best suited to the training and skills of providers and teams, and can further help identify competency gaps amongst teams to help drive training and hiring planning (see Figure 1).

The front and back-stage activities presented in the next section may represent entirely new work by providers and managers or an expansion and re-design of activities already in place. Adaptive change approaches outlined in the implementation practice guide may be particularly useful in re-design work as it will involve modification of the existing work flows rather than necessarily putting in entirely new activities and processes. Activities may require expanded roles for providers and managers who will need to engage in new ways of thinking about work (new cognitive models) as part of the shift towards more integrated models of care (Nutting et al., 2011).

Table 1 maps the 32 activities of integrated care models to the attributes of patient and caregiver experience and organizes them into front-stage and back-stage work of providers and managers. In reviewing the table, it should be noted that: 1) provider and manager activities are mapped to the first 4 attributes that are specifically related to care processes. These activities are expected to result in achieving the last 2 outcome-oriented attributes (independence and safety); and 2) providers and managers sometime share activities in the front- or back-stage. These shared roles of front-line providers and leaders point to the importance of engaging in bottom-up change discussed in the implementation practice guide.

Finally, we note some activities as "foundational," meaning they do not align to specific attributes of patient and caregiver experience, but rather act as important enablers to the other activities listed above. As such, these activities mainly occur at the back-stage.

Figure 1/ The four types of activities that are important for integrated care.



Front-stage and back-stage activities can be defined as...

1/ Provider front-stage

Activities that are patient- or caregiver-facing. These are any activities involving interactions between providers and patients or their caregivers, whether synchronous or asynchronous (e.g., clinic visits, phone calls, video conferencing, emails).

2/ Provider back-stage

Activities that are provider- or manager-facing. These are any activities involving interactions with other health or social care providers (internal or external to their organization), volunteers or managers, or independent administrative and preparatory work (e.g., charting, case conferencing, training and education) without direct contact with patients or caregivers.

3/ Manager front-stage

Activities that are patient-, caregiver- or provider-facing. These are any activities involving interactions with patients, caregivers, or health or social care providers (internal or external to their organization), volunteers or managers.

4/ Manager back-stage

Activities that are manager- or stakeholder-facing. These are any activities involving interactions with other managers (internal or external), care delivery stakeholders (from collaborating organizations), policy stakeholders (health ministries and regionally-based organizations with a mandate to drive care delivery or quality), other funders (e.g., charitable, not-for-profit and philanthropic funders), or independent administrative and preparatory work stakeholders (e.g., preparing staff meetings, problem resolution, change management, any co-design work).

Table 1/ The 32 activities of integrated care mapped to attributes of patient and caregiver experience.

Foundational activities		
These activities are at the provider and managerial level and cross cut the attributes by enabling other activities	**For both providers and managers** > Supporting experimentation in design and delivery of collaborative, patient-centered care > Supporting adoption and meaningful use of IT systems > Engaging in regular performance measurement and quality improvement activities and initiatives **Provider back-stage** > Developing approaches to manage the cost of delivering integrated care services	**Manager front-stage** > Supporting clinician involvement in service planning, and implementation of new initiatives **Manager back-stage** > Creating forums and opportunities for learning from external experts and organizations > Ensuring providers and case managers have appropriate and feasible caseloads > Ensuring that organizational mandates and strategic directions continually promote integrated care as a core mission > Developing approaches to manage the cost of delivering integrated care services

Attribute 1

Being heard

Examples

- Provider focuses on the person outside the diagnosis
- Provider probes for personal context outside of health care to understand family/ social life, interests, and priorities for patients and caregivers
- Patients and providers talk to each other, sharing appropriate information so everyone knows what is going on.

Provider front-stage

1/ Giving patients and caregivers opportunities to share what is most important to them in their care and including these preferences in individual care planning and decision making

2/ Addressing broader determinants of health that impact patient and caregiver's experiences

Provider back-stage

3/ Exchanging information (such as patient records or notes) with providers within your organization and across health and social care continuum.

4/ Using technologies to improve information exchange, service delivery, access to data, and communication for client care

5/ Ensuring specific patient data is routinely collected in health records so that all team members have the same information

6/ Building effective professional and interpersonal relationships with providers and other members of each individual patient's healthcare team

7/ Engaging in inter-professional teamwork (with health care providers from other disciplines), within your organization and outside of your organization (e.g., creating shared-care plans)

Manager front-stage

8/ Using technologies to improve information exchange, service delivery, access to data, and communication for client care

9/ Ensuring patients and service providers from different sectors can access and share information electronically (e.g. patient records/ charts.)

10/ Ensuring shared understanding among the healthcare team regarding roles, responsibility, accountability, and communication

11/ Building effective professional and interpersonal relationships with providers and other members of each individual patient's healthcare team

Manager back-stage

12/ Addressing broader determinants of health that impact patient and caregiver's experiences

13/ Ensuring specific patient data is routinely collected in health records so that all team members have the same information

Attribute 2

Having someone to count on

Examples

Having a trusted 'go-to'-person (typically a paid provider) who is:

- Responsive and can connect to the broader team when needs arise
- Accessible so the patient/caregiver have direct contact details and able to reach them directly
- Easily identifiable for patient/caregiver

Provider front-stage

14/ Routinely monitoring patients' status (e.g. strategically scheduled follow-up assessments)

15/ Ensuring that patients and caregivers have someone they can contact if health and social care needs arise

Provider back-stage

16/ Ensuring case managers have appropriate skills and expertise to execute their roles

Manager front-stage

17/ Ensuring that patients and caregivers have someone they can contact if health and social care needs arise

Manager back-stage

18/ Ensuring case managers have appropriate skills and expertise to execute their roles

Attribute 3

Knowing how to manage health and what to expect

Examples

- Instill confidence in patient and family by teaching them skills to self-manage
- Providing instructions, written list of steps, how-to guides on how to manage symptoms, and activities (e.g. specific exercises to support better function)

Provider front-stage

19/ Promoting and supporting self-management practices

20/ Linking patients, families and/or caregivers to informational/educational and community resources

Manager front-stage

21/ Involving patients and caregivers in service (co)-design and organizational decision-making processes

22/ Linking patients, families and/or caregivers to informational/educational and community resources

23/ Promoting and supporting self-management practices

Attribute 4

Easily accessing health and social care

Examples

Access enabled by having a 'go-to' person who:

- Works to connect and facilitate access to health and social resources
- Wears multiple hats so both health and social needs can be met simultaneously (e.g., physician who teaches tai chi, social worker that can provide transportation tokens or liaise with housing support)
- Mobilizes services and resources

Provider front-stage

24/ Identifying a single point of access for onboarding and assessing new patients

25/ Facilitating transitions across care settings for patients and caregivers

Provider back-stage

26/ Following clear and consistent criteria to identify patients who will benefit from integrated community-based health and social care services

27/ Ensuring effective flow and tracking of patient referrals (i.e. referrals are accepted, sent and followed up on, within your organization and across other organizations in the health and social care continuum)

Manager front-stage

[26/] Following clear and consistent criteria to identify patients who will benefit from integrated community-based health and social care services

[27/] Ensuring effective flow and tracking of patient referrals (i.e. referrals are accepted, sent and followed up on, within your organization and across other organizations in the health and social care continuum)

28/ Facilitating transitions across care settings for patients and caregivers

Manager back-stage

29/ Identifying a single point of access for onboarding and assessing new patients

30/ Building collaborations with organizations within the local healthcare geography to promote improvements to patient care

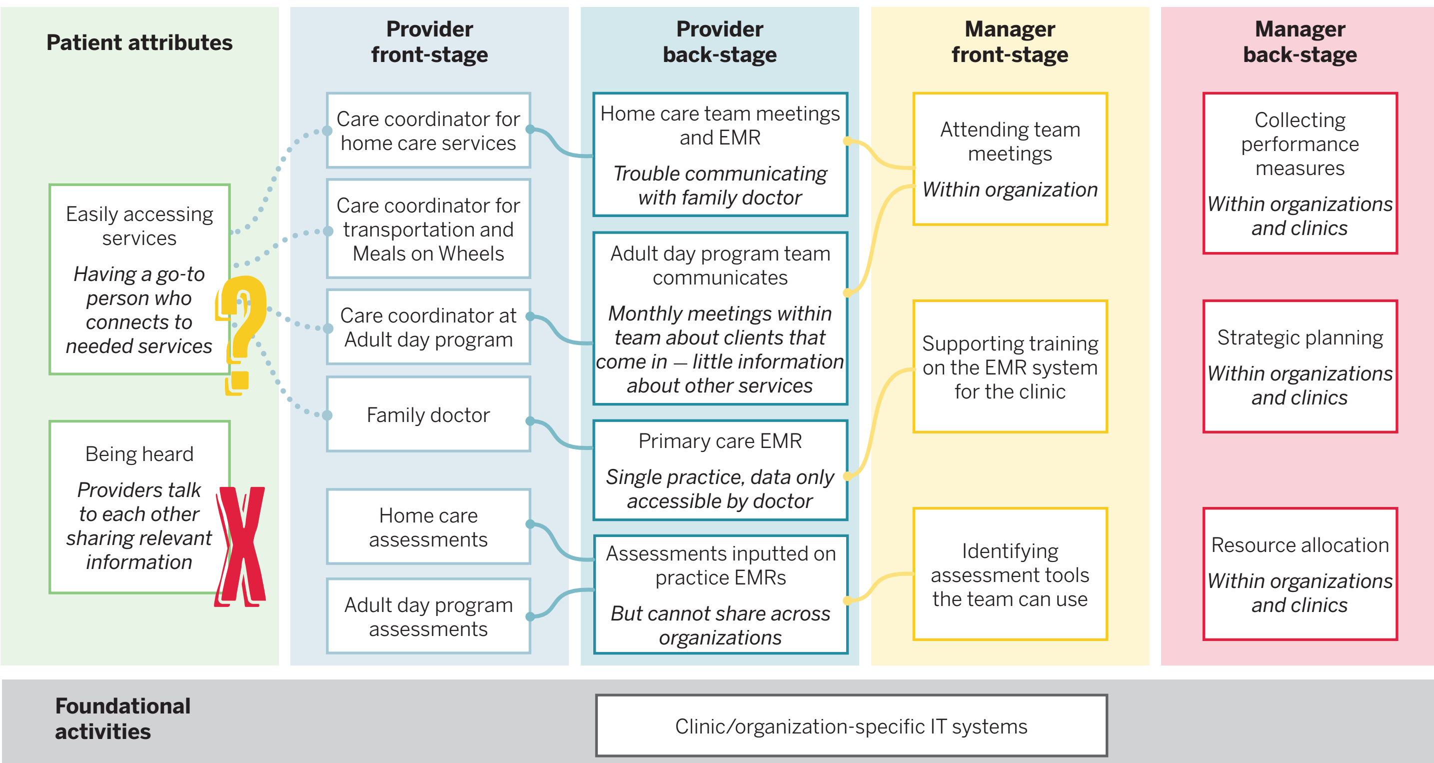
31/ Developing formalized agreements between organizations (e.g., data sharing or co-location agreements)

32/ Assessing patient and population needs to inform the planning of services

SCENARIOS

To demonstrate how these activities may change what is already being done on a day-to-day basis, we present activity maps around the two scenarios of Mrs. Lee presented in the patient and caregiver practice guide (also included in the appendix for this guide). In these scenarios, we see two very different stories unfold after Mrs. Lee, an 87-year-old widow, wakes up feeling unwell one day. Figure A below illustrates what activities are in place when her needs are not understood nor addressed. Figure B depicts the activities in place when her needs are met.

Provider and manager activities when needs and preferences of Mrs. Lee and her daughter are NOT understood and addressed and the process of care is broken.

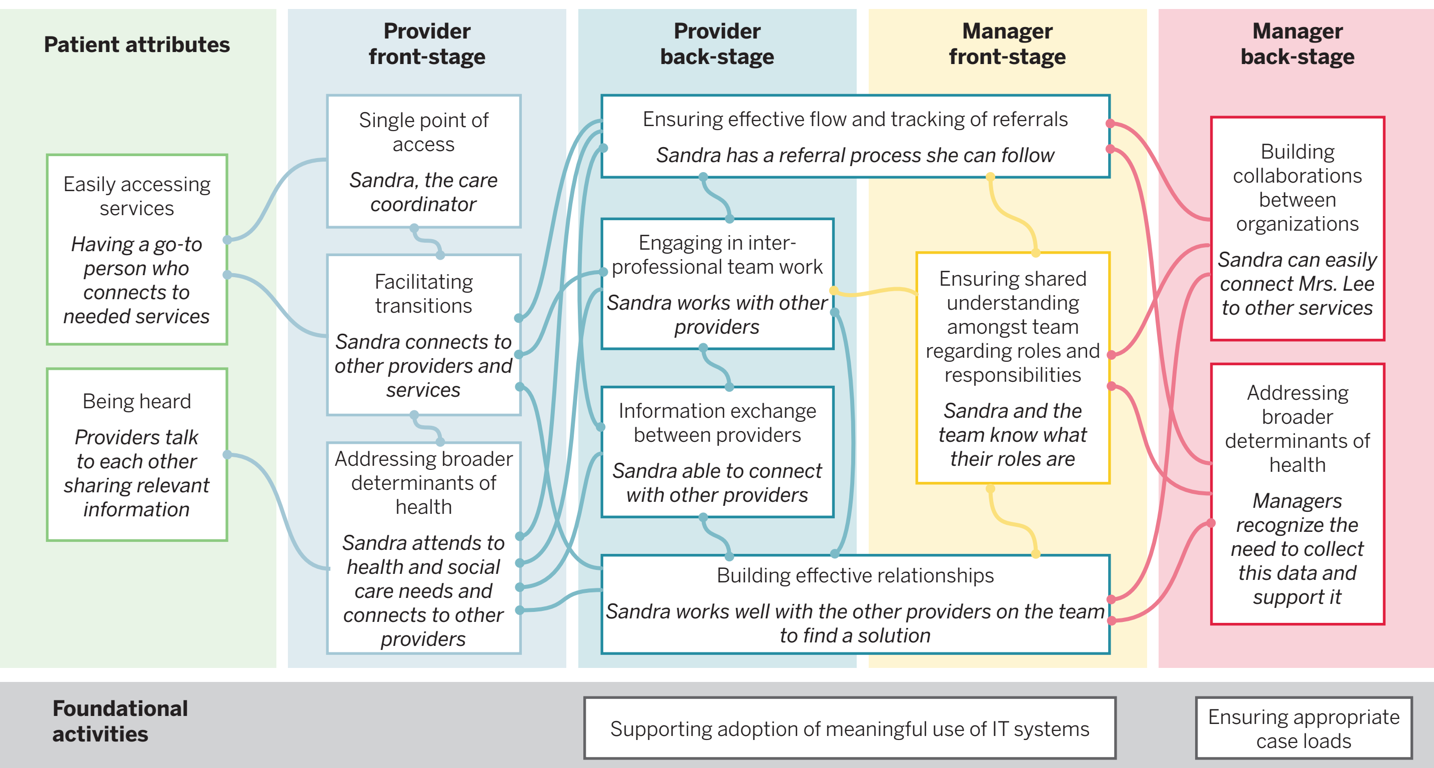


Discussion of Scenario A

The model of care offered to Mrs. Lee has many components that have likely helped her in her care to this point. She has access to a primary care doctor and care coordinators that have been providing her with care plans and health and social care services to help her stay independent at home. The breakdown in this scenario happens early on. While Mrs. Lee seems to have a lot of support, a clear single point of contact with a person that Mrs. Lee and her daughter trusts to deal with this situation has not been established.

All the supporting structures at the back-stage and managerial level are similarly fragmented, offering support only to their single teams or organizations rather than creating meaningful connections across the team. The components are in place, but there is no communication between the players, leaving Mrs. Lee and her daughter uncertain of what to do, who to go to for help, and thus ending up in the ER with unnecessary secondary negative outcomes.

Provider and manager activities when needs and preferences of Mrs. Lee and her daughter are understood and addressed and the process of care is integrated.



Discussion of Scenario B

In this second scenario Mrs. Lee has many of the same services available as in the first scenario, the key difference being that she and her daughter know to call Sandra who has established good relationships with her other providers and a strong communication pathway. Sandra additionally addresses broader determinants of health for both Mrs. Lee and her daughter, attending to caregiver burnout in a proactive way. As can be seen in Figure B, Sandra's ability to work with Mrs. Lee and her daughter and connect them to the health and social services required is reliant on a number of back-stage activities, notably:

- Providers afforded the ability to exchange information with other providers within and across organizations, enabled through available technologies
- Providers engaging in inter-professional teamwork within and across organizations
- Managers supporting the building of effective professional and interpersonal relationships between providers in the circle of care
- Managers ensuring a shared understanding of the team regarding roles, responsibilities, accountability and communication
- Managers building effective professional and interpersonal relationships and partnerships across organizations

While Sandra, the care coordinator, is doing much of the front-stage work in this scenario, she may also need to hand-off care to someone on his team. For instance, where Sandra was able to call other providers to get advice regarding Mrs. Lee's medication in this scenario, many models could also facilitate home visiting by multiple team members, such as a physician's assistant, pharmacist, or family physician, who could come in to Mrs. Lee's home to assess her needs in collaboration with Sandra, Mrs. Lee and Mrs. Lee's daughter to determine the best course of action.

Establishing flexible staffing and funding models that can adapt to changing needs of patients can support this type of team work. Alternately using technologies like video conferencing, and secure messaging, can help the team to easily connect and trouble shoot. Keeping in mind potential restrictions on professional roles will also be important in determining the best individuals to be involved in these more flexible positions. For instance, unionized professions may experience more barriers to adaptation and variation in work processes.

The relationship between these activities cannot be understated and demonstrates that providers and managers will require diverse skills sets to engage in both front-stage and back-stage activities. In this mapping we can see that providers need clinical skills to engage with patients and families, as well as strong collaborative and teamwork skills to work with other professionals. Managers also not only require skills in directing staff, but they also need good relational skills, as well as an ability to build a collaborative culture within and across organizations.

Co-designing a front-stage back-stage map

The activities list linked to front and back stage activities offered in Table 1 can act as a starting point to identify what activities will help meet patient/client values and outcomes. It should be noted some of these activities are identified in generalized ways (e.g., ensuring that patients and caregivers have someone they can contact if health and social needs arise). We purposely do not specify who this person needs to be on the team as we have found these details are best left to be determined by the teams who need to adapt these activities to their own contexts.

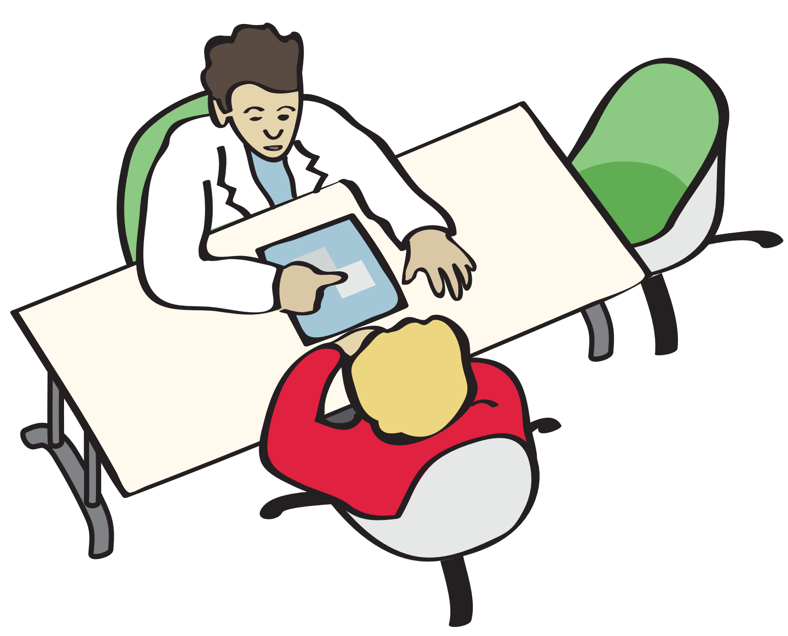
For example, one model may rely on a single care coordinator who would act as the central point of contact for all patients on their roster, whereas another model may deploy an inter-professional team and the main point of contact may be the individual with whom the patient/client is most comfortable. Both examples work well in different contexts. In order to determine the best way to operationalize these activities we suggest working together with the providers and managers delivering the services to establish processes (Ham and Walsh, 2013), and, where possible with patients and families as well (Rocco, 2016). We further recommend revisiting these processes regularly to adapt, modify and refine, particularly in the early phases of implementation outlined in the implementation practice guide.

How to know if you are doing this well

The advantage of mapping front and back-stage activities of providers and managers is that it can help identify where there may be gaps in processes that are impeding progress towards programs goals. As can be seen in the difference between Figures A and B, the linked activities

show where different providers and managers need to act in the process of delivering care. If evaluations are demonstrating that the program is falling behind addressing any of the 6 attributes of patient and caregiver experience, go back to the activities map to see where the problems may be. It is recommended this activity is done with all providers and managers involved in the activity chain so different perspectives can be represented.

The mapping of activities also offers an opportunity to engage in co-designing solutions with providers and managers (as well as patients and families), which can improve team engagement. When an issue arises look to the maps created together. The scale ratings done at the beginning of this section can also be revisited to check-in on these core components of delivering an integrated model of care. Discuss as a team how to move the dial.



Three key takeaways

1

Identify what activities you are already doing across partners at both the front-stage and back-stage and see where there are gaps. Think about how activities are interconnected and co-dependent. Components already in place may require adaptation and modification to align with an integrated model with network partners.

When building teams of providers and managers, think about the diverse skill sets needed to be able to engage in both front-stage and back-stage activities. Often both clinical and relational skills will be required to be successful in both front-stage and back-stage roles.

The 32 activities of providers and managers can, and should, be adapted to local contexts through co-designing with providers, patients and families.

EXERCISE: MAP YOUR ACTIVITIES

Now that you have learned about front-stage and back-stage activities for integrated care, use the steps below to map out the activities needed to achieve one of the 6 patient and caregiver attributes within your OHT. Remember, integrated care is a team sport – do this exercise with your team.

To map your activities...

- [ ] Pick one value from the 6 that matter most to patients and families that you'd like your OHT to tackle.
- [ ] Map out the front-stage and back-stage activities of all partners in your OHT to achieve the attribute, including both provider and manager levels. Some of these activities may already be in place and some may be new. Use the 32 integrated care activities to help you.
- [ ] Next draw links between the activities, and try to identify who on the team will engage in these activities. The links will help you visualize how you need to structure teams and communication processes to enable your activities in your OHT.
- [ ] Finally identify what can help you realize this vision and what might be standing in your way. Think about how you can mitigate these barriers.

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APPENDIX: SCENARIOS

The following two scenarios are presented in the practice guide for patient and caregiver engagement and illustrate a real-world example of what it looks like when the needs and preferences of the patient and caregiver are understood and addressed versus not.

Poor outcomes

Needs and preferences of patient and caregiver are NOT understood or addressed.

One day...

Mrs. Lee woke up feeling unwell. She's an 87-year-old widow and lives alone in her apartment. Her daughter, Laura, just returned from a short vacation and tries to reach her Mom by phone, and after several tries there is no response. She drives over to check on her. When she arrives, her Mom appears confused and tells her daughter that she feels dizzy.

There have been several coordinators involved in her Mom's care and she is unsure who to contact. She doesn't feel comfortable calling the primary care doctor directly so she calls 911 and her Mom is taken to the emergency room where she waits for several hours. Laura and her mother meet with several people where they have to repeat their story over and over again.

They decide to keep her overnight to run tests. Due to a lack of rooms she is in a stretcher in a hallway where it's noisy and unfamiliar. Laura is exhausted and frustrated at the lack of timely response to her Mom's needs. Her Mom is scared and eats very little, making her feel increasingly tired and weak. She misses another dose of her medication as she waits and is feeling increasingly dizzy.

On her way to the washroom she has a fall and fractures her hip and is now waiting for surgery. Given the lack of operating rooms she waits for several days and then catches pneumonia which further delays her surgery. Laura, the sole family caregiver is exhausted, confused, frustrated and takes several days off work without pay so she can be there to advocate for her Mom who doesn't speak English.

APPENDIX: SCENARIOS

The following two scenarios are presented in the practice guide for patient and caregiver engagement and illustrate a real-world example of what it looks like when the needs and preferences of the patient and caregiver are understood and addressed versus not.

Good outcomes

Needs and preferences of patient and caregiver are understood and addressed.

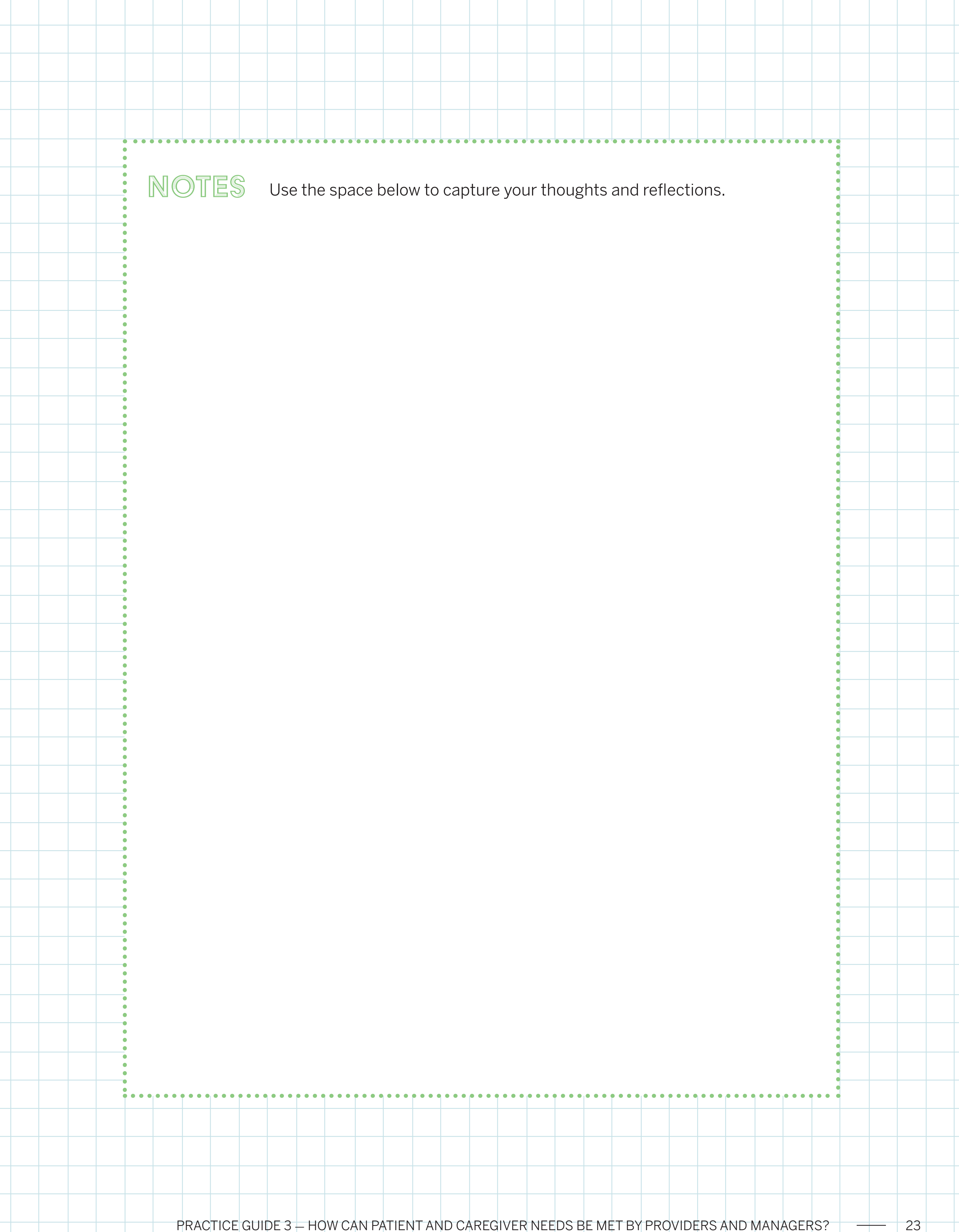
One day...

Mrs. Lee woke up feeling unwell. She's an 87-year-old widow and lives alone in her apartment. Her daughter, Laura, just returned from a short vacation and tries to reach her Mom by phone, and after several tries there is no response. She drives over to check on her. When she arrives, her Mom appears confused and tells her daughter that she feels dizzy.

Their care coordinator, Sandra, whom Mrs. Lee and Laura have gotten to know quite well over the years, always encourages them to call if they need something. Mrs. Lee doesn't feel comfortable asking for help, but her daughter knows to contact Sandra when something is wrong. She rings Sandra and she answers quickly and listens to Laura's concerns. During this phone call her Mom starts to feel better but is very tired.

Sandra is in regular contact with Mrs. Lee's primary care team and is able to arrange a home visit with her primary care provider that afternoon. During the home visit Mrs. Lee has her vitals checked and blood work done and later it's determined that she needs to adjust her medication. The primary care doctor calls the pharmacy and arranges for the new medication to be dropped off.

During this visit it's also clear that Laura is feeling burnt out and is concerned about leaving her Mom alone for long periods of time during the day while she is at work. The primary care doctor shares this with Sandra who connects back with Laura to tell her about a Day Program that caters to the Chinese population. Since the day program is with her Chinese speaking peers, Mrs. Lee agrees to go, and her daughter, who gets to know the staff, feels comfortable knowing that her Mom is happy and safe. Attending the program also helps Mrs. Lee feel independent as she does not want to move into a long-term care facility.



NOTES

Use the space below to capture your thoughts and reflections.