Primary care physicians' perspectives on facilitating older patients' access to community support services

Qualitative case study

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Abstract

Objective To understand how family physicians facilitate older patients' access to community support services (CSSs) and to identify similarities and differences across primary health care (PHC) models.

Design Qualitative, multiple-case study design using semistructured interviews.

Setting Four models of PHC delivery, specifically 2 family health teams (FHTs), 4 non-FHTs family health organizations, 4 fee-for-service practices, and 2 community health centres in urban Ontario.

Participants Purposeful sampling of 23 family physicians in solo and small and large group practices within the 4 models of PHC.

Methods A multiple-case study approach was used. Semistructured interviews were conducted and data were analyzed using within- and cross-case analysis. Case study tactics to ensure study rigour included memos and an audit trail, investigator triangulation, and the use of multiple, rather than single, case studies.

Main findings Three main themes were identified: consulting and communicating with the health care team to create linkages; linking patients and families to CSSs; and relying on out-of-date resources and ineffective search strategies for information on CSSs. All participants worked with their team members; however, those in FHTs and community health centres generally had a broader range of health care providers available to assist them. Physicians relied on home-care case managers to help make linkages to CSSs. Physicians recommended the development of an easily searchable, online database containing available CSSs.

Conclusion This study shows the importance of interprofessional teamwork in primary care settings to facilitate linkages of older patients to CSSs. The study also provides insight into the strategies physicians use to link older persons to CSSs and their recommendations for change. This understanding can be used to develop resources and approaches to better support physicians in making appropriate linkages to CSSs.

EDITOR'S KEY POINTS

- Many communities have an array of community support services (CSSs) to assist older adults and their caregivers, but these services are often accessed at low rates. Patients and their families report looking to their family physicians for information about available CSSs, but there is limited research on physicians' awareness and use of CSSs for older patients.
- This study aimed to understand how family physicians facilitate older patients' access to CSSs and to identify similarities and differences across primary health care models.
- Physicians reported relying on the expertise of team members and often delegated to these individuals the responsibility for linking patients with CSSs, but physicians in fee-for-service practices had fewer team resources. Physicians thought that an easily searchable "one-stop-shop" online database with all available CSSs would be helpful, and identified the need for a single referral agency. Where such resources already exist, they might need to be better promoted to primary care physicians or they could be incorporated into electronic medical record systems.

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Points de vue des médecins de première ligne sur les mesures visant à faciliter l'accès des personnes âgées aux services d'aide communautaires

Étude de cas de type qualitatif

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Résumé

Objectif Déterminer ce que les médecins de famille font pour faciliter l'accès de leurs patients âgés aux services d'aide communautaires (SAC) et vérifier en quoi les différents modèles de soins primaires (MSP) se distinguent à ce point de vue sur ce plan.

Type d'étude Étude de cas multiples de type qualitatif à l'aide d'entrevues semi-structurées.

Contexte Quatre modèles d'établissements dispensant des soins, incluant 2 équipes de santé familiale (ESF), 4 organismes de santé familiale non-ESF, 4 établissements utilisant la rémunération à l'acte et 2 centres de santé communautaires urbains en Ontario.

Participants Échantillonnage par choix raisonné de 23 médecins de famille qui pratiquent seuls ou en petits ou grands groupes, dans les 4 MSP.

Méthodes On a utilisé l'approche de l'étude de cas multiples. On a tenu des entrevues semi-structurées, et les données ont été soumises à des analyse individuelles et inter-cas. Les tactiques utilisées pour s'assurer de la rigueur des conclusions de l'étude comprenaient des notes et un système de vérification (audit trail), la contribution de plusieurs chercheurs (investigator triangulation) et l'utilisation de plusieurs études de cas plutôt qu'une seule.

Principales observations Trois thèmes principaux ont été identifiés : le fait de communiquer avec les membres de l'équipe et de les consulter afin d'établir le lien; le fait de mettre le patient et sa famille en rapport avec les SAC; et le fait de se fier à des ressources désuètes et à des stratégies inefficaces pour se renseigner sur les SAC. Les participants travaillaient tous avec les membres de leur équipe; toutefois, ceux des ESF et des centres de santé communautaires pouvaient généralement compter sur un plus large éventail de soignants pour les aider. Les médecins, pour leur part, se fiaient aux responsables des soins à domicile pour orienter les patients vers les SAC. Ils recommandaient en outre la création d'une base de données sur les SAC qui serait facile à consulter sur le WEB.

Conclusion Cette étude démontre l'importance d'un travail au sein d'une équipe interprofessionnelle pour faciliter l'accès des patients âgés aux SAC. Elle nous renseigne aussi sur les stratégies que les médecins utilisent pour mettre les personnes âgées en contact avec les SAC ainsi que sur les modifications qu'ils proposent. De telles données pourraient servir à développer des ressources et des moyens pour mieux assister les médecins qui veulent aider leurs patients dans ce domaine.

POINTS DE REPÈRE DU RÉDACTEUR

- Plusieurs municipalités offrent un ensemble de services d'aide communautaires (SAC) aux personnes âgées et à leurs aidants naturels; ces services sont souvent offerts à de faibles tarifs. Ces personnes mentionnent souvent que c'est auprès de leur médecin de famille qu'elles s'informent des SAC disponibles; il existe toutefois peu d'études sur ce que les médecins connaissent de ces services et sur la façon dont ils renseignent ces personnes.

- Cette étude visait à vérifier de quelle façon les médecins de famille facilitent l'accès aux SAC par les personnes âgées, et à déterminer les ressemblances et les différences entre les divers modèles de soins de santé primaires.

- Les médecins ont dit se fier aux connaissances des membres de leur équipe et leur confier souvent la responsabilité d'informer les patients sur les SAC; toutefois, ceux qui étaient rémunérés à l'acte ne comptaient pas beaucoup de membres dans leur équipe. Les médecins estimaient qu'il serait utile d'avoir une base de données incluant tous les SAC disponibles, qui serait facilement repérable sur le WEB; ils ont de plus mentionné la nécessité d'avoir un site d'aiguillage unique. Lorsque de telles ressources existent, il faudrait les faire mieux connaître aux médecins de première ligne; elles pourraient aussi être incorporées dans les systèmes des dossiers médicaux électroniques.

Cet article a fait l'objet d'une révision par des pairs.
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Many communities have an array of community-based health and support services to assist older adults and their caregivers. Community support services (CSSs) are delivered in the home or community to assist people with health or social limitations in maintaining the highest possible level of physical and social functioning, as well as quality of life. Examples of CSSs include meal services, transportation services, day programs, volunteer visiting, and caregiver support services. Use of such services positively affects older adults and their caregivers.[1,2] However, older adults and family caregivers use CSSs at very low rates[3] and have limited awareness of CSSs. Lack of awareness of available services leads to failure to recognize service needs and an inability to access appropriate services, and is a strong predictor of unmet service needs.[3-6]

Older adults obtain information about CSSs from various sources including service providers, informal sources such as family members, and media sources such as television.[7-9] Family physicians and physicians' office staff have been identified as the most preferred and important sources of information on CSSs.[7,10-12] A recent study used a series of 12 vignettes to describe common situations faced by older adults for which CSSs might be appropriate.[10,12] In telephone interviews with 1152 older persons aged 50 years and older, an average of 26% of respondents (and as high as 71%) indicated that they would turn to their family physicians for help in the described situations. Thus, it is critical that physicians are aware of and able to link older adults to CSSs. Physicians have been identified as "mediators," "boundary spanning agents," and "gate-keepers" in this area.[13]

However, there is limited research on physicians' awareness and use of CSSs for older patients. Some studies have found that physicians have greater knowledge of health-related services, such as home health agencies and skilled nursing facilities, compared with social services or CSSs, such as adult day care, housing, and congregate meals.[13-15] A number of studies focused on physician awareness and use of services specifically for patients with dementia and their caregivers.[16-19] Physicians were much more likely to refer patients with dementia to home health agencies (83%) and nursing homes (82%) than to CSSs such as respite or adult day care (57%) or the Alzheimer's Association (31%).[18] Many physicians noted that they lacked knowledge about or confidence in community resources for their patients, and rarely referred patients or families to Alzheimer societies.[19]

There are a number of limitations to the existing literature. Most studies included not only primary care physicians but also some combination of other health professionals such as internists, neurologists, doctors of osteopathy, and general surgeons.[13,14,16-18] This limits the ability to generalize results specifically to primary care physicians, who are a main and regular point of contact for most older adults. Only 3 studies provided any information related to the types of practices represented, with fee-for-service (FFS) and solo practices being the most common.[14,17,18] This is particularly important given the increasing trend toward interprofessional team models of primary health care (PHC) in countries such as Canada.[20] We did not find any studies examining how primary care physicians facilitate linking older patients to CSSs or differences across models of PHC. In 3 studies, a list of community health and support services was provided to physicians to check off or rate their awareness of specific services,[14,15,17,18] leading to overclaiming or acquiescence bias.[21] Finally, much of the published literature is out-of-date, having been published in the 1980s and 1990s.

In summary, there are important gaps in our understanding of how primary care physicians respond when older patients need CSSs, and we do not know if similarities and differences exist across PHC models. This understanding is critical in developing approaches to improving physicians' ability to facilitate effective links between older adults and CSSs with the potential of improving quality of life, sustaining independence in the community, reducing visits to the emergency department, reducing hospitalization, and decreasing or delaying institutionalization. The purpose of this study was to understand how family physicians facilitate older patients' access to CSSs and to identify variations in the approach to making linkages across different PHC models.

METHODS

Design and settings

A qualitative, multiple-case study design was used.[22] Case studies are most appropriate to answer "how" and "why" questions regarding a contemporary phenomenon about which there is little research.[22] An exploratory case study approach was used to discover what primary care physicians (hereafter referred to as *physicians*) do when interacting with older patients who need CSSs. We made reasoned assumptions that physicians' responses to older patients needing CSSs might vary depending on the type of PHC model they work in, given the differences in interprofessional teams available in such models. Thus, we included 4 cases in this study, each representing a type of PHC model common in Ontario: family health teams (FHTs), non-FHT family health organizations (FHOs), FFS practices, and community health centres (CHCs).[20] **Table 1** describes each model in detail. In general, FHTs are most likely to have the broadest range of interprofessional health care providers as team members, while FFS models are least likely to include a range of interprofessional providers. Further, FHTs

are also most likely to have an assigned home-care case manager who regularly attends team meetings and facilitates connections with CSSs. The presence of these interprofessional teams facilitates *interprofessional collaboration,* defined as occurring when "learners/practitioners, patients/clients/families and communities develop and maintain interprofessional working relationships that enable optimal health outcomes."[23] The study was conducted in Hamilton, Ont.

Table 1. Description of PHC models

PHC MODEL	DESCRIPTION
FHT	FHTs consist of interprofessional teams of health professionals (eg, family physicians, nurse practitioners, nurses, counselors, dietitians, pharmacists) who provide comprehensive care to patients with a focus on chronic disease management and disease prevention. Most FHTs are physician-governed. FHT physicians are paid using a blended capitation model that includes various incentive payments. Some FHTs are academic FHTs and are also committed to training health professionals
FHO	FHOs also provide comprehensive care to their patients. Some FHOs have access to additional funds that enable them to hire other health professionals to provide special programs, such as mental health, nutrition, and foot care. FHO physicians are paid using a blended capitation model that includes various incentive payments
FFS practices	FFS physicians are paid for services rendered and rarely employ health professionals other than nurses
CHC	Like FHTs, CHCs provide comprehensive care through interprofessional teams. CHCs differ from FHTs in their emphasis on community development and the social determinants of health. CHCs have community governing boards. Physicians in CHCs are paid a salary

CHC—community health centre, FFS—fee-for-service, FHO—family health organization, FHT—family health team, PHC—primary health care.

Participants

Physicians (N=23) were purposively sampled from sampling frames of the family practices within each of the 4 PHC models.[24] Where possible, maximum variation sampling was used to include solo and small and large group practices (**Table 2**). Various recruitment strategies were used, such as meeting with executive directors of the teams or practices, attending practice team meetings, and meeting personally with physicians to discuss the study. Participant demographic characteristics are presented in **Table 3**.

Data collection

Face-to-face, in-depth semistructured interviews were conducted with physicians by a trained research coordinator. An interview guide (available on request) was developed based on a review of the literature and the team's previous experience and research in the area of CSSs. Participants were asked to describe what they do when an older patient needs CSSs; describe the resources and health care professionals they turn to for help in linking older patients with CSSs; respond to 2 vignettes (**Box 1**) related to older adults requiring CSSs; and make recommendations to improve their ability to link older patients to CSSs. Vignettes were used to address acquiescence bias and constitute a well established research approach.[25,26] The interviews, approximately 30 minutes in length, were conducted between October 2009 and January 2011. Interviews were conducted in a quiet room at the workplace of participants and were audiorecorded and transcribed verbatim.

Analysis

Transcriptions were entered into NVivo8 software to help with data management. Data analytic strategies

Table 2. Participating family practices and family physicians by model of primary care

CHARACTERISTICS	CASE A	CASE B	CASE C	CASE D
Model of primary care	FHTs	Non-FHT FHOs	FFS practices	CHCs
No. of practices and physicians participating in study	2 FHTs • 2 solo practices (2 physicians) • 2 small group practices (2 physicians) • 2 large group practices (4 physicians) • 1 academic practice (3 physicians)	• 1 solo practice (3 physicians) • 2 small group practices (2 physicians) • 1 large group practice (1 physician)	• 2 solo practices (2 physicians) • 2 group practices (2 physicians)	2 CHCs • 2 physicians

CHC—community health centre, FFS—fee-for-service, FHO—family health organization, FHT—family health team.

Table 3. Demographic characteristics of participants: *N* = 23.

CHARACTERISTICS	N (%)*
Sex	
• Female	7 (30)
• Male	16 (70)
Years in practice	
• 0-14	4 (17)
• 15-24	9 (39)
• ≥ 25	10 (43)
Proportion of older adults (≥ 65 y) in practice	
• 0.0%-25.0%	12 (52)
• 25.1%-50.0%	10 (43)
• 50.1%-75.0%	1 (4)
• > 75.0%	0 (0.0)
Model of primary care†	
• FHT	11 (48)
• Non-FHT FHO	6 (26)
• FFS practice	4 (17)
• CHC	2 (9)

CHC—community health centre, FFS—fee-for-service, FHO—family health organization, FHT—family health team.
*Proportions might not add to 100% owing to rounding.
†The proportion of physicians recruited in each model of care was broadly representative of the number of practices in the community at the time.

were used based on the work of Yin[22] and Miles and Huberman.[27] The principal investigators (J.P., M.D.) and research coordinator jointly conducted the data analysis, and preliminary findings were discussed with the other investigators as the analytic process continued. Transcriptions were read and reread. Line-by-line coding of the data was conducted using both in vivo codes (arising from the data themselves) and the research and interview questions. A coding list was developed, applied by 2 team members to the first 4 transcripts, revised, and applied to the remaining transcripts. The processes used by physicians to link older adults with CSSs were contrasted and compared within models of PHC and then across models (cross-case synthesis). We developed word tables[22,27] that displayed the processes used to link older adults to CSSs in each case and analyzed these tables for similarities and differences.

A number of case study tactics were used to ensure the quality of this study, consistent with Yin's approach.[22] Memos were written and an audit trail was maintained that outlined decisions during data collection and analysis. Investigator triangulation, involving the use of several different investigators in the analysis process, facilitated a deeper understanding of data from multiple perspectives. The use of multiple, rather than single, case studies contributed to external validity given the inclusion of multiple PHC models and practices of different size.

Box 1. Vignettes and interview questions

Vignette 1: Mrs Brown
Your patient Mrs Brown is the main caregiver for her parent who has Alzheimer disease. She has discovered that her mother has been taking more pills than she should. What would you do if Mrs Brown came to you in that situation?

Vignette 2: Mrs Jones
Your patient Mrs Jones comes to you and says that owing to her poor health she is no longer able to do her shopping, housework, or yard work. Her family members are busy and she doesn't want to bother them. What would you do if Mrs Jones came to you in that situation?

Interview questions related to the vignettes
- Is there a community support service that you can think of that could provide help to Mrs Brown or Mrs Jones in that situation?
- Is there anyone in your practice you would turn to for help to link Mrs Brown or Mrs Jones to community support services?
- Are there any resources or services that you would turn to for helping to decide where to refer Mrs Brown or Mrs Jones for help?
- How comfortable are you with your ability to link older persons in situations like those of Mrs Brown or Mrs Jones to community support services?
- What kind of resources, services, or supports do you feel you need to help you link older persons such as Mrs Brown or Mrs Jones to appropriate community support services?

Ethics approval

Ethics approval was granted by the Hamilton Integrated Research Ethics Board. The research coordinator ensured informed consent, collection of signed consent forms, and protection of participant confidentiality.

FINDINGS

Almost all physicians (91%) identified the Alzheimer Society, while few (17%) identified adult day programs as possible CSSs in response to the first vignette (caregiver of a patient with Alzheimer disease). For the second vignette (patient unable to do housework and yard work), only 35% of physicians identified a CSS related to housework and yard work, and 44% identified Meals on Wheels as a possible CSS. In both scenarios, many physicians said they would consult with the home-care agency as a way of addressing needs for CSSs.

The following themes were identified from physicians' responses to both the general and vignette-specific questions: consulting and communicating with the health care team to create linkages; linking patients and families to CSSs; and relying on out-of-date resources and ineffective search strategies for information on CSSs. Themes are described below and illustrative quotations are identified by participant number and model of PHC. The similarities and differences in linking with CSSs across models of PHC are then described, followed by physicians' recommendations to improve linkages with CSSs.

Themes

Consulting and communicating with the health care team to create linkages. Physicians explained that they consulted and communicated with health care team members to facilitate linkages with CSSs for older patients. This included both consulting with team members to obtain information about available CSSs so physicians could initiate connections themselves and delegating to team members the responsibility for making the linkages. Physicians stated that they most frequently consulted with nurses (registered nurses, registered practical nurses, clinical nurse specialists, and nurse practitioners) who they believed had extensive knowledge of CSSs (**Table 4**). For example, one physician stated:

> [Registered practical nurses and nurse practitioners] provide a lot of help; [they are the] number one tool for assisting me .... The nurse practitioner I work with ... certainly knows our community well and so she knows what's out there, and sometimes if I'm not sure if there's something I'll ask her. (006 FHT)

Physicians also consulted other available team members, such as social workers, mental health workers, dietitians, pharmacists, and clerical staff to learn about CSSs. Some health care professionals provided useful information about resources for certain conditions: "Our mental health counselor ... [is] somebody that I'll ask sometimes ... particularly if there are mental health issues." (009 FHT)

Overall, physicians used the knowledge and experiences of all team members to seek out "what else is sort of new out there [and to] ... sort of pick their brains with things." (016 FFS)

Some physicians expressed a lack of experience or a gap in their knowledge and skills to connect older adults with CSSs:

> Family doctors have some knowledge but it's an incomplete amount of knowledge. It's just that there's a lot of stuff to know and a lot of services and it's hard to keep up. (002 FHT)

> I don't think I'm very good at it ... in terms of linking them up with a particular agency. (013 FHO)

Physicians also acknowledged their time and resource constraints in making these linkages themselves:

> My financial resources are limited .... I've got to deal with all these issues within the 10-minute [patient visit] period. It's time-consuming. Time is dollars. And there's no extra funds allotted to the family doctors to sit down and talk about all these things. It's nice to have other people out there. (013 FHO)

As a result, many physicians stated that they do not initiate the call themselves, but instead delegate and designate team members to facilitate linkages, make telephone calls, and follow up on the linkage with CSSs:

> For getting patients linked to services I would always have my nurse get involved. I would either bring her in at that point or I would send her a to-do in the [electronic medical record (EMR)] and say, "Could you please look into this or set this up for this patient?" And I rely completely on my nurse .... My own skill level and knowledge is probably not as good as it should be .... She's the sort of system advocator. (004 FHT)

Where physicians did not have large teams, they would ask clerical staff to "contact, whether it be by phone or fax or whatever the appropriate method, the community resource, initiate the referral process." (019 FFS)

Some physicians who had social workers on their teams spoke of the value of their role in assessing patients in their homes for needed CSSs. One physician stated:

> [The social worker] would go into their home ... she reports back to me [and] writes a note on every

Table 4. Health care professionals physicians worked with to facilitate linkages to CSSs

HEALTH CARE PROFESSIONAL	N (%)
Registered nurses	23 (100)
Home-care case managers	23 (100)
Mental health worker	17 (74)
Dietitian	17 (74)
Social worker	15 (65)
Pharmacist	12 (52)
Nurse practitioners	8 (35)
Registered practical nurses	6 (26)
Other	9 (39)

CSS—community support service.

> visit, which I'd read .... She would arrange to meet the patient again or she often will contact whatever services might be required and try and arrange things for [the patient]. (010 FHO)

Some physicians thought that making these linkages was not only beyond their expertise but outside of their role:

> I'm now becoming a coordinator of social services, which is going outside of my own personal realm of expertise .... And that's where I start questioning what is my role as a trained physician, trained in medicine. Am I really the most effective person? (012 FHT)

In response to the vignettes, physicians most commonly identified home-care case managers as resources to help link older adults to CSSs. Physicians relied on case managers to provide advice and take the lead on connecting older adults to the most appropriate CSSs.

> If the client comes in or the family comes in and says, "We're not getting what we hoped. We need more help." Then I usually just call the case manager. Speak to them myself .... I rely fairly heavily on [them] to be up to date on what they can and can't do and what's out there. (009 FHT)

Physicians would often have the case managers "do an assessment of home safety and personal care issues," (004 FHT) which helped to determine care needs and the appropriate resources to fill the gaps. In some practices, case managers were part of the team, which facilitated monthly patient conferences.

> I have found it very helpful ... [when the case manager] comes in once a month with her list of people that are on home care ... and we will discuss the patients .... She's gone in and assessed them in the home. A lot of it's around placement issues or what we can do to support them being in the home and so I find that absolutely invaluable. (008 FHT)

In practices where other health care providers were available and accessible, physicians engaged in face-to-face communication with team members: "We case conference together once a week ... if there's a ... complex patient with high risk who we're worried about ... [the team] will come together and somebody will case manage that." (015 CHC)

When certain health care professionals were not available and additional expertise was required, physicians contacted them by telephone: "If I don't have any experience or no idea, I would probably call one of the geriatricians that I use regularly and just see what they can provide or what their advice is." (023 FFS) Physicians in the FHT model used e-mail or the EMR to communicate with the team.

Linking patients and families to CSSs. Physicians often described how they developed strategies for linking patients and families to CSSs. Strategies included giving information about CSSs to patients and families, encouraging families to access the CSSs on behalf of patients, and initiating linkages for patients and families who required assistance. One physician explained the importance of CSSs in supporting patients and families:

> We recognize that linking to the community support services is really key along with patient engagement and empowerment in their care. We recognize that we can't do it all alone .... It's about the patient and their family ... and community agencies are a really important part of the network of care and support. (004 FHT)

Some physicians stated that they would provide the name and contact information of the CSS to the patient and their family often in the form of pamphlets or brochures: "It might be me giving the name to the patient or the caregiver to contact .... Occasionally if we have brochures around then we'll give the brochures out." (002 FHT)

Other physicians provided information if they were familiar with certain services suitable to the patient. As one physician stated, "If I happen to know of something, I will tell them about it." (004 FHT)

Of interest, some physicians described reaching out to the patient's family and friends to assist with care before reaching out to available CSSs. One physician described a process of identifying patient needs, assessing receptivity to services, exploring alternatives to CSSs, determining if family could address the needs, and then discussing possible CSSs:

> My first step would be to label the need, address whether they [patients and family] agree that this was a need, whether they were receptive to the provision of service, whether there were alternatives to reaching out to a community resource, meaning where there are family members that might be able or would want to fill this void. And then if the need was still present then discuss the resources that I was aware of. (019 FFS)

Physicians indicated that they would "involve [the patient's] family in decisions about what sort of help they needed and how much the family could provide." (010 FHO)

Most physicians explained that they would provide family members with information regarding a service

and expect them to advocate for their relative by connecting with the necessary CSSs:

> Oftentimes I will provide the information but charge the family member with the connection piece .... I find that usually the patient and the family member are much better at actually distilling down. I mean, a patient doesn't often do it if you leave it with them. But if there is a family member that you connect with and who's acting as an advocate, then they're usually quite keen to access the services that would be helpful to their parent or to their spouse. (006 FHT)

Physicians explained that many CSSs are obtained through self-referral and that they rely on family members to make this type of connection:

> And if it's one [a referral] that the family needs to arrange themselves, they'll leave the office with contact information. And we'll ask them if it's a self-referral, to follow through with us by phone to let us know that they've initiated that process. And if we have a family member present, we will usually give the information, with the patient's permission, to the family member. (019 FFS)

If the patient or family was unable to make the telephone call themselves, then physicians would take it upon themselves to make the linkage:

> [I would give them] a piece of paper assuming that there's somebody advocating for them or they can do it themselves .... If they couldn't do it I don't mind making a phone call at all and getting a start for them. (022 FHO)

Another physician described making the initial contact just to ensure the correct referral path:

> We would contact whoever it is we're trying to do and make sure that we have the right referral path—phone numbers, addresses, contact people—[either] we do it and inform the patient or give that information to the patient or the family and get it going from there. (020 FHO)

Follow-up of linkages with CSSs was only mentioned by a few participants. Physicians would "want to follow up with [the patient and their family] and see if what we put in place had any effect." (014 FHT)

One physician talked about following up with the patient in subsequent visits about how things were going since the linkage to the CSSs: "I'll say [during the next visit] how are things going with your mother? Did you get the help you were looking for? How are you doing mentally, emotionally? Following up with [him or her]." (009 FHT)

Another physician stated that he and his team would not follow up, saying "it would be up to the patient and their family to follow through." (011 FHO)

Relying on out-of-date resources and ineffective search strategies for information on CSSs. Many physicians referred to the use of out-of-date resources and ineffective search strategies when determining the appropriate CSSs for older adults. They commonly described using "The Red Book," which was developed by a local community information service and last updated in 2007. The hard-copy binder included a listing of community health and support agencies, the services provided by that agency, and contact information. The book lacked an easy search mechanism and was not updated regularly.

> At one point in time we had this binder of all the community resources. What I found is that it tends to be a little bit out-of-date. And it wasn't updated frequently so you'd find a resource and they're no longer around ... there was too much almost. (002 FHT)

Physicians also described using a handbook called *Family Physicians Guide to Community Resources*. Like The Red Book, this provided a listing of community health and social services but was not updated regularly:

> The other thing we have, and I'm not sure mine's up to date, is this community resources book. *Family Physicians Guide to Community Resources*. And this, I must say I don't use a lot .... I'm just looking here and I see services for older adults in here. (008 FHT)

A few physicians referred to using free flyers, pamphlets, and loose-leaf booklets for information about CSSs:

> Well, sometimes they have pamphlets that come through. They're very beneficial .... And I tend to have those shoved on the desk or somewhere like that .... Sometimes I'll see one that I find beneficial and I'll ask for more to be sent to us. Rarely will I do it if it costs us anything. (021 FHO)

Physicians described using various Internet websites and online searches to find information on CSSs. Some mentioned looking on the local city website and the related public health resources: "[I] use [the city website], particularly the public health portion [as] they do have a comprehensive resource listing." (019 FFS)

Some physicians described performing a Google search, often with few valuable results, to find information about CSSs. Physicians working in a FHT described using their own website, which provided a list of local CSSs:

> [The FHT has] a list on [the website] of what sort of groups there might be, like caregiver burnout groups .... They're always offering different things. So, I might look on there, see if there's anything that looks appropriate. (003 FHT)

Physicians described their lack of awareness of a central site on the Internet to find appropriate CSSs, which resulted in ineffective and inefficient search strategies.

Comparison across primary health care models

There were similarities and differences in the ways physicians made linkages with CSSs both within and across PHC models. At the level of the individual physician, self-reported knowledge, experience, and use of CSSs varied from those who felt very comfortable and confident making linkages to CSSs (13%), fairly or reasonably comfortable (57%), to very uncomfortable and lacking in confidence (30%).

All participants consulted and communicated with their team members; however, those in FHTs and CHCs usually had a broader range of health care providers available to assist them. Because FHT and CHC models generally consist of interprofessional teams, physicians worked alongside other health professionals in the same clinical area, which facilitated ease of communication: "It's nice to have people on-site because they all work with me here at the office; it's nice to just literally go down the hall, knock on the door, and ask a question." (007 FHT)

On the other hand, physicians working in FFS models do not readily have access to the same variety of professionals, as most of these practices only consist of the physician and a nurse or clerical staff. Physicians stated that because "there's only me and my secretary ... I do rely quite a bit on the front desk." (018 FFS)

These physicians (and those from other models) expressed the need for more accessible and available social workers to be part of the team to help facilitate counseling and coordination of services for their clients: "It's absolutely horrible. We need more availability of the social worker .... Getting people assessed by social workers and counseling and that kind of thing." (013 FHO)

In the FHO model, there is additional funding that enables the hiring of health care professionals with specific skills, such as mental health counselors. Physicians without these supports described the challenges they faced in making linkages with CSSs:

> A common problem [is that] I'm the doctor looking after medical health. This is a woman who needs help in the house with her facilities. If it's not based on illness, somebody else has got to come in. That sounds terrible as I say that, but that's not my role as a family doctor .... Everything dumps down back on the family doctors. Family doctors should be doing all these things. And in the real world, yes, if we had staff to do that kind of thing, marvelous, but I don't have the staff, the resources to do it .... My job is health issues. How are they functioning? They can't cut their grass. You know what? I'm sorry, but it's not my job. Should it be? Maybe in a perfect world, yeah. (013 FHO)

Physicians relied on different resources for CSSs depending on the PHC model in which they practised. Although physicians in the FHT used The Red Book and other written materials from time to time, they also had high confidence in their own team members and therefore used these professionals as their primary source for information about available CSSs. On the other hand, physicians working in FFS practices had few staff and often relied heavily on The Red Book and any pamphlets and handouts mailed to them by community agencies and organizations. Almost all physicians from all PHC models mentioned using the Internet as one of their sources, although not all physicians specified which websites they visited. Physicians identified a lack of a central point of access with an up-to-date listing of available CSSs. However, these comments reflected a lack of awareness of 2 existing databases of CSSs, one focused specifically on older adults developed by a regional geriatric program and one focused on a range of services developed by a community information service.

Across the 4 PHC models, all physicians relied on home-care case managers for their knowledge related to CSSs and their roles in conducting home and safety assessments and connecting patients and their families with appropriate CSSs. However, the FHT practices in this study had specific case managers assigned to their teams, which facilitated ongoing communication and regular face-to-face meetings to discuss patient needs. Other PHC models were more likely to have different case managers working with them and to communicate via telephone or e-mail only.

Recommendations to improve linkages with CSSs

Physicians made a number of recommendations to improve their ability to link older adults to CSSs. The 2 main recommendations, consistent across models of PHC, were related to the need for an easily searchable "one-stop-shop" online database with all available community services, and the need for a single referral agency (**Table 5**).

DISCUSSION

The study findings shed new light on how primary care physicians facilitate linkages with CSSs for older adults and the similarities and differences in approach across different models of PHC. The key findings are that physicians consult and communicate with health care team members

to facilitate linkages; physicians develop strategies for linking patients and families to CSSs; and physicians often use out-of-date materials and ineffective search strategies to find information on available CSSs. Each key finding is explored within the context of previous literature.

First, physicians relied on the expertise of team members and often delegated to these individuals the responsibility for linking patients with CSSs. The multiplicity and complexity of older adults' care and social needs requires a variety of health care professionals with diverse expertise to work together to address unmet needs and facilitate optimal care. Physicians reported frequently consulting with nurses, social workers, and home-care case managers for help. There is considerable value in linking with professionals within and across teams in primary care. In particular, home-care case managers play an integral role in identifying older adults' needs for CSSs and linking them appropriately. According to the Canadian Home Care Association,[28] it is crucial for home-care case managers to align and collaborate with family physicians through formalized and structured partnerships to create health teams that are equipped to provide optimal patient care. These partnerships can result in better understanding of available community resources, more timely introduction of resources, and more time for physicians to focus on complex clinical client issues.[28]

Physicians who worked in interprofessional team models of PHC reported that they consulted extensively with other health care team members in making linkages to CSSs, while physicians in other models of PHC counted on their office support staff for this assistance. In this study, physicians who worked in FHT models benefited from having an interprofessional team, which offers a larger pool of knowledge and established relationships with CSSs than are available in conventional FFS practices. This interprofessional team model provides opportunities to work collaboratively to identify the most appropriate services for a given patient and their caregivers. As in other studies, physicians readily identified their own lack of knowledge about CSSs, as well as the barriers of lack of time during office visits and tensions related to their roles in making these connections.[13,14,16,18,19]

Table 5. Summary of recommendations made by physicians to improve linkages to CSSs

RECOMMENDATIONS	SAMPLE QUOTES
1. Availability of a "one-stop-shop" online database • Physicians want a searchable, easy-to-read, regularly updated database that is accessible to both health care providers and clients and their families in the community • The database or directory should have the contact information, the cost, and availability of the different services in the community in addition to a brief description of each service • The database or system rates the various community supports and services in terms of usefulness	• "[I would like] a really useful, easy-to-read, accessible, up-to-date database that's searchable and quick and readily available. I think that would expand the access to that information to other people as well. So it wouldn't just be a repository in one person who when she retires or goes on vacation we're screwed. I would like it online. And searchable. Ideally right inside my EMR or on my server so I don't have to waste time going to somebody else's website that I'm uncomfortable with. Ideally a kind of searchable database that's locally available and updated. I think if my nurse has the same thing it would be very helpful. And there are other members of the team that would also take more advantage of it. For example, if the pharmacist or the dietitian are seeing someone who is senior and needs some help in nutrition, if they also had ready access to a database that's searchable, I think that would be very helpful. So, that others on the team develop that expertise, instead of everyone sort of going to the nurse" (004 FHT) • "I think if there was a system in place to come up with different services and contacts, I would hope that that system would kind of rate them at the same time and say these are the ones we found that are the top 2 or top 3, if you were going to look at them [or that] I wouldn't recommend these because we didn't find them useful or [they] are actually detrimental in some cases" (023 FFS)
2. Need for a single referral agency • Physicians describe the need for a central agency that assesses and refers patients and their families to appropriate CSSs • The referral agency would also provide suggestions of relevant CSSs for the physician	• "If there's an agency like the [home-care agency name] who is a one-contact service that would look at the problems of the elderly and sort out the dilemma of where people should go [for CSSs], I would think that would be excellent. We have in the adolescent group and children CONTACT. CONTACT is the group you send them [to]. And they sort out what your problems are and where they can be directed. We need a "CONTACT" for [older] adults, if that's available" (013 FHO) • "I guess it would be nice and maybe this exists so there you go ... to have like a central registry where you could just call or you could send in a quick fax and just outline a very basic [need] and just have them at least even just spit out back or contact you again with suggestions or contact the family with suggestions or however you wanted it to be set up" (006 FHT)

CSS—community support service, EMR—electronic medical record, FFS—fee-for-service, FHO—family health organization, FHT—family health team.

Second, this study described how physicians develop strategies to link patients and families to CSSs. Physicians appear to consider options for linkage, often starting with simply giving the patient or family information on the service and expecting them to make the linkage, moving to "charging" the family member with making the linkage for the patient, and then making the linkage on behalf of those patients or families who required assistance. Involving older adults and their families as key decision makers in care is crucial to effective practice and has been shown to be cost-effective while enhancing the quality of community care.[29]

Finally, physicians in this study often relied on out-of-date materials and ineffective search strategies to find information on available CSSs. Yaffe and colleagues[19] found that only 17% of family physicians maintained office reference lists of community services. Some physicians in team practices had lists of services available on EMRs, but many others did not. Physicians in all models of primary care recommended central listings of available CSSs that could be easily searchable as well as a central access point for CSSs.

There are a number of implications for practice and policy based on this research. Primary care physicians are key agents in identifying and responding to the needs of older adults and families related to CSSs. They are, indeed, "boundary spanning agents"[13] and together with their interprofessional team members, play critical roles in facilitating these linkages. Within Canada, there have been numerous primary care reform initiatives implemented, with most provinces and territories incorporating interprofessional team-based care.[30] This type of care provides a range of resources for family physicians to rely on in facilitating linkages to CSSs, as evidenced by accounts of FHT physicians in this study. Team-based models of health care have been shown to lead to better health outcomes for clients with chronic diseases, increased access to health care, and improved patient experience.[31]

Given the complexity of the community health and social service systems, new primary care roles such as patient navigator, psychologist, and physician assistant might be valuable to help link older adults to CSSs. Patient navigators can be health care professionals or laypeople who assist particularly vulnerable individuals with obtaining needed supports and transitioning between care sectors.[32] They have also been referred to as *care managers, care coordinators,* or *patient coaches* and take on a central role in primary care to deliver and coordinate services for patients, including coordinating care across clinicians, settings, and conditions or diseases.[33] Most of the research on navigators has been conducted in the area of cancer,[34-36] and more recently stroke care.[37] The guided care intervention was designed to enhance the quality of health care of older adults with multimorbidity within a primary care setting.[38] This multicomponent intervention included supports to access community resources and was found to improve ratings of chronic care by patients. Primary care physicians in the guided care intervention groups were more likely to report improvements in communication with patients and caregivers, improvements in self-management, knowledge of patient medications, and community referrals to CSSs.[39] Further research is needed on the effects of system navigators for older adults in primary care.

Physicians described using technology to facilitate linkages to CSSs, particularly in facilitating communication between health care professionals and identifying relevant services for older adults. Information technology to support clinical practice is essential to the provision of high-quality, efficient primary care.[30] Physicians commonly lamented the lack of a central access point (on the Internet and an agency contact) for information and referral to CSSs, even though there were 2 Internet-based information services available for the community. One option is that such services become part of the EMR.

There are some recent innovations that hold promise for increasing awareness of CSSs among patients and providers. In Canada, for example, some communities have introduced 211 as a telephone and Internet (**http://211.ca**) information service about various community and other support services. In Ontario, community care access centres have created a website that lists information about health and social services (**www.thehealthline.ca**). In the United Kingdom, AgeUK offers an advice line about services for older adults (**www.ageuk.org.uk**). Similarly, in Australia, My Aged Care is a telephone service where staff provide information about aged care services and develop a personalized client record that holds information about individual clients and the services they receive (**www.myagedcare.gov.au**). In the European Union, EUGENIE (European Generating Engagement in Networks Involvement)[40] is an innovative intervention involving the development of maps of personal and community support networks for people with chronic conditions. The intervention provides lists of resources tailored to individual needs and interests using an online navigation tool. Research is needed to evaluate the effects of these innovations.

Overall, study findings provide an enhanced understanding of how primary care physicians facilitate linkages to CSSs by working with the interprofessional team members, planning with patients and family members, and using both written and electronic sources of information. This understanding is valuable in guiding future strategies to improve these

linkages and ultimately improve the quality of life of older adults.

Study strengths and limitations

A study strength is the use of a case study approach that examines similarities and differences in physicians' linkage of older patients to CSSs across 4 PHC models. Further, the use of vignettes provides a hypothetical context that closely approximates real-life decision-making situations. Study limitations include the use of only one city within one province and the fact that the diversity in PHC models in this city is not reflective of all models of PHC.

Future research

Future research is needed to understand how the health care team members physicians work with facilitate linkages to CSSs for older adults, such as a recently completed study by this research team.[41] There is also a need to develop and evaluate strategies to help physicians and other health care providers to improve linkages to CSSs, including the use of technology. Further, there is a need to understand how primary care practitioners facilitate linkages to CSSs for older adults from multicultural and multiethnic backgrounds. Last, there is a need for the development of educational initiatives to increase awareness and use of available CSSs among older persons, their family caregivers, physicians, and other health care providers.

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Contributors

Drs Ploeg, Denton, Hutchison, McAiney, Moore, Brazil, and **Tindale** conceived of and designed the study and obtained the funding. **Drs Ploeg** and **Denton** coordinated the study. All authors participated in data analysis. **Dr Ploeg** and **Ms Lam** took the lead on drafting the manuscript. All authors read, revised, and approved the final manuscript for submission.

Competing interests

None declared

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