Insights on the RICHER Initiative

Judith Lynam, RN, PhD

Overview

RICHER Theory

RICHER Philosophy

RICHER Model

RICHER Research

R esponsive
I ntersectoral & Interdisciplinary
C hild
H ealth
E ducation &
R esearch

CIHR IRSC

Acknowledgments

Research Colleagues
C. Loock, S. Wong, L. Scott, B Fitzsimmons, V. Munroe, B. Palmer, L. Irwin & B. Fitzgerald
Research Manager: K. Khan
Undergraduate Research Assistants: A. Mann, K. Berndt, J. Lui and D. Valenzuela.

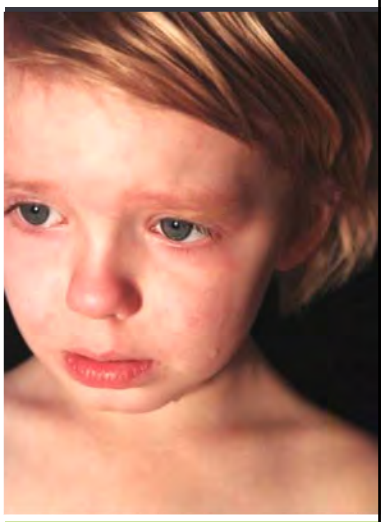
Funders CIHR, CNA and MSFHR & BCMSF

Community Partners
NEVCO
Ray Cam
Child Health BC
Vancouver Native Health

UBC Academic Partners
School of Nursing
Faculty of Medicine

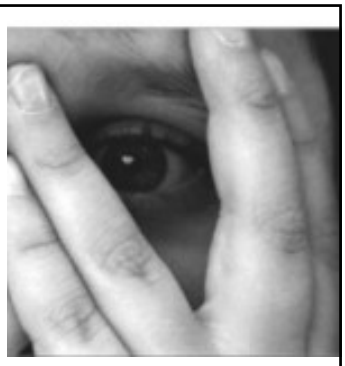
Health Authorities
Provincial Health Services Authority
BC Children's, Sunny Hill & BC Women's
Vancouver Coastal Health Authority (VCHA)

GOAL - appropriate access to primary care and specialized services



In our research programme, we have sought to understand:

- the influences on access to health services
- the components of the RICHER approach that foster access for some of our most 'vulnerable' children

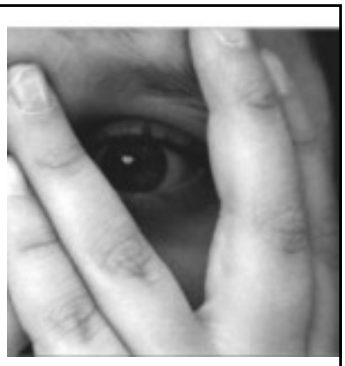


RICHER Research

Theoretical Underpinnings of RICHER

Newest Analysis…

- Does RICHER foster access for children vulnerable because of their social and material circumstances?
- What characteristics of the RICHER approach are correlated with (indicators of) positive outcomes?



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RICHER Research

Effects of inequities are cumulative over the life course…

Many of the 'interventions' to support child development are **firmly rooted in the child and family's social world.**

Inequities (disparities) in health

Among those who are poor, **social relationships are protective**….
The negative health impacts of material poverty can be mitigated.

Inequities are socially 'determined'

Engagement
Cohesion
Participation

Healthcare systems contribute most to **improving health and health equity** where institutions and services are organized around the principle of universal coverage…and where the system as a whole **is organized around Primary Health Care** (…action **across the social determinants of health**, the primary level of entry to care with **upward referral**).

Commission on Social Determinants of Health, 2008

Role of Health Systems in Addressing Inequities

Characteristics of Primary Health Care associated with better health outcomes:

ACCESS

RESPONSIVENESS

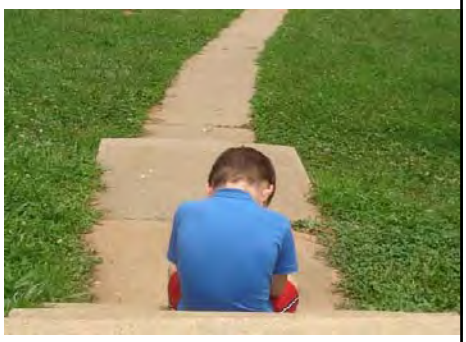
SOCIAL DETERMINANTS OF HEALTH

…both access and responsiveness are shaped through relationships.

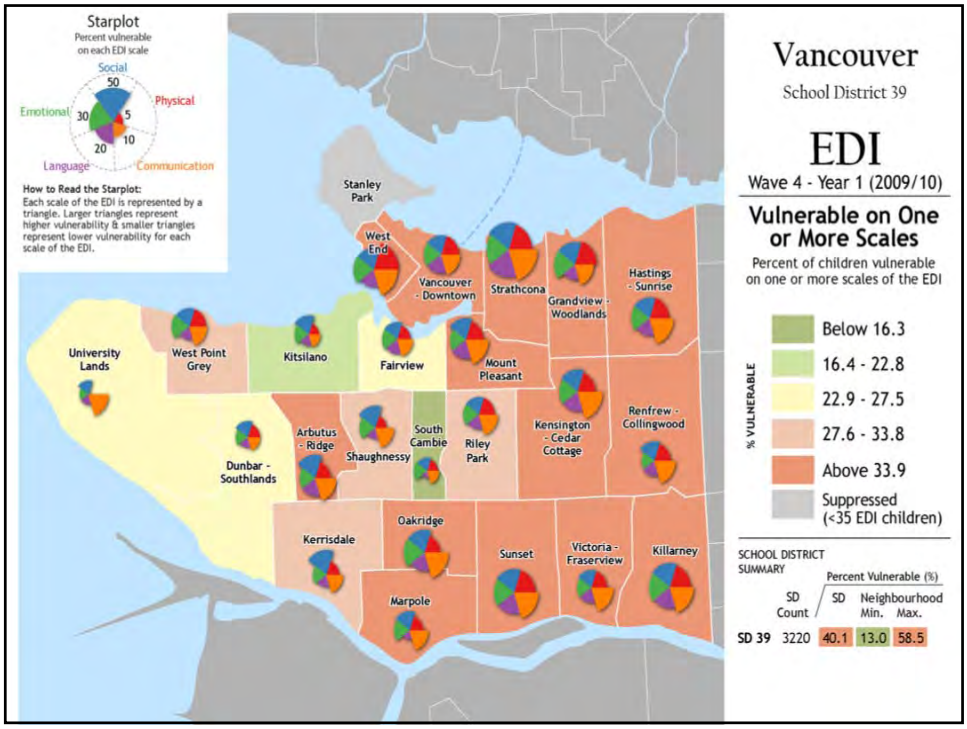
Role of Health Systems in Addressing Inequities

Purposeful integration **activities within 'place'** foster individuals' sense of cohesion, connection and relationship.

Role of communities in reducing inequities in health



Fostering cohesion
Creating infrastructure
Fostering linkages
Capacity building



RICHER & Social Pediatrics

Complement existing population health programmes

Services are provided in the child's **neighbourhood**

Partnership with community resources

Social Pediatrics

Building clinical **relationships** that extend and enrich families' social relationships

Ensuring **parents are supported** to nurture their child's development.

Tailoring **communication**, providing direction and support in ways that foster the child's development.

Researching Social Pediatrics

Participatory methods to ask research questions identified as **priorities within the community** and to conduct the study in ways that **are respectful of the community.**

To **understand** the nature of **barriers to access** for children in families vulnerable because of their social and material circumstances

To explicate the tenets of the **RICHER** approach

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Research Goals Phase I

Does RICHER foster **access**…?

What impact does RICHER have on **patient outcomes**?

Parents' ratings of RICHER:
- Access
- Continuity
- Responsiveness
- Relationship

Empowerment, which is associated with:
- Satisfaction
- Compliance
- Optimal HS utilization
- Positive orientation
- Patient activation

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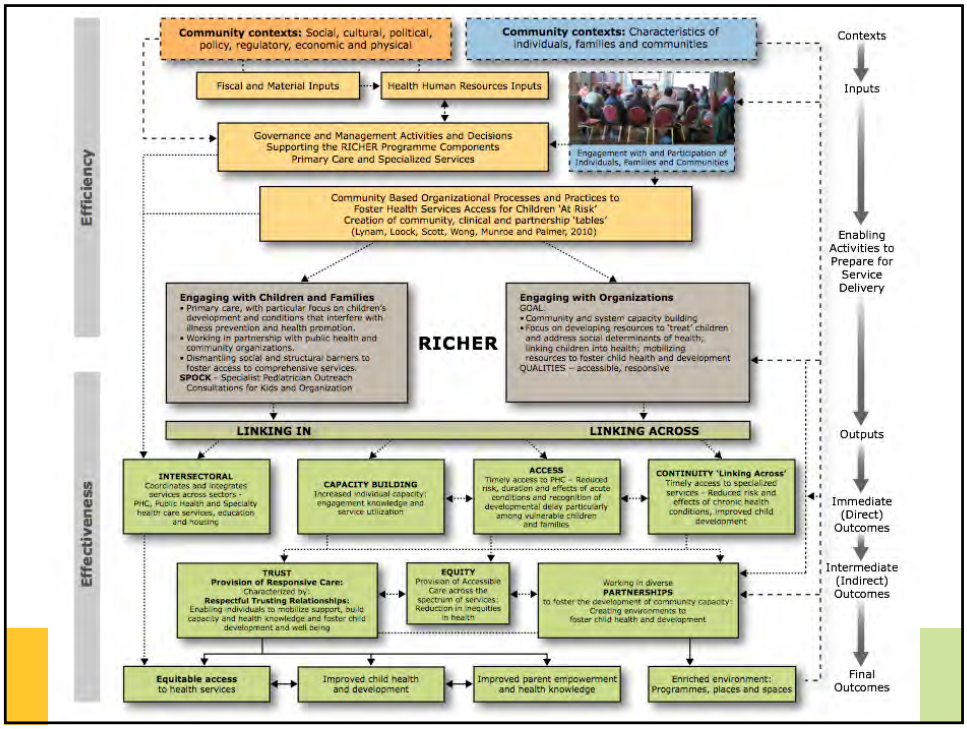
Research Goals Phase II



Eligibility for Phase II Questionnaire

English or Cantonese-speaking families

Used RICHER primary care services at least once in last 12 months

Recruited in community spaces

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Questionnaire incorporated scales designed to reflect important **dimensions of PHC**

All items have undergone rigorous forward-backward translation to ensure **semantic equivalence**.

Follow-up **qualitative interviews**

RICHER Research

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Data Analysis

Demographic Profile

Independent variables

Strength of affiliation

Interpersonal communication

Clarity of communication

Explained results

Shared decision-making

Interpersonal style

Dependent variable

Empowerment

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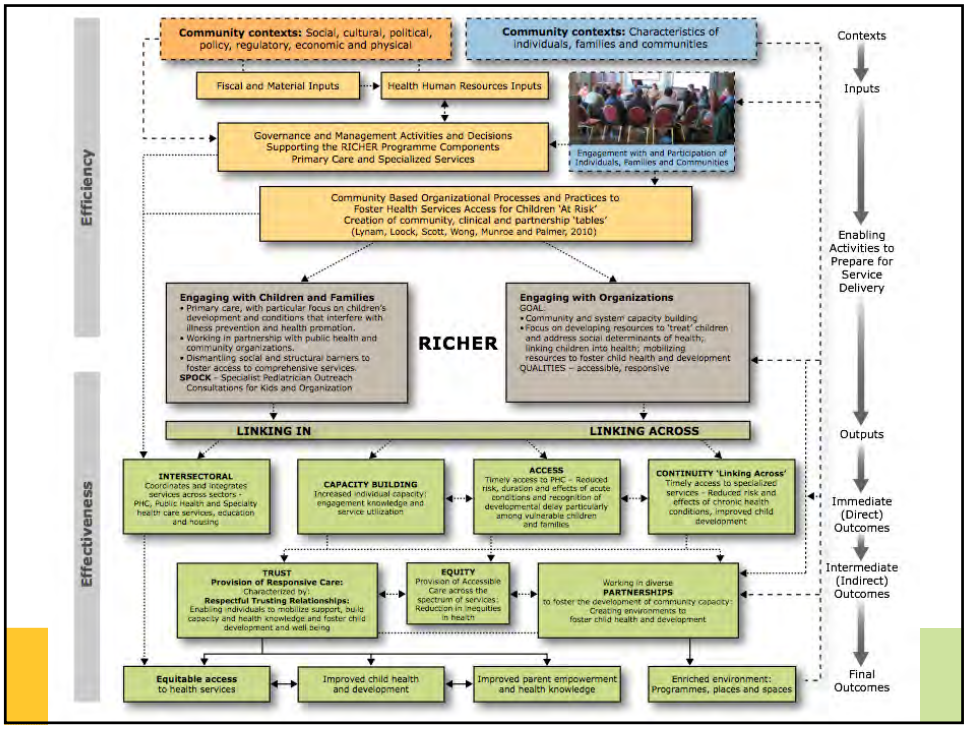

Reflecting on RICHER Results Phase I

Barriers to access are social and structural

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Reflecting on RICHER Results Phase I

Outreach enacted in Partnership

1.Building relationships and **trust** and conveying **respect fosters access**

2.Partnerships enabled families to **'link in'** to traditional clinical services, and enabled clinicians to **'link across'** to specialized services

3.Partnerships enabled families to **access services** and resources to **address the social determinants** of health

Accountability and mechanism for engagement – the role of the Community table

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RICHER Results Phase II

Does RICHER foster access for a population of children and families with multiple forms of social and material disadvantage?

The particular profile of the study participants show that **RICHER *does* foster access to PHC** for children who are vulnerable because of their social and material circumstances.

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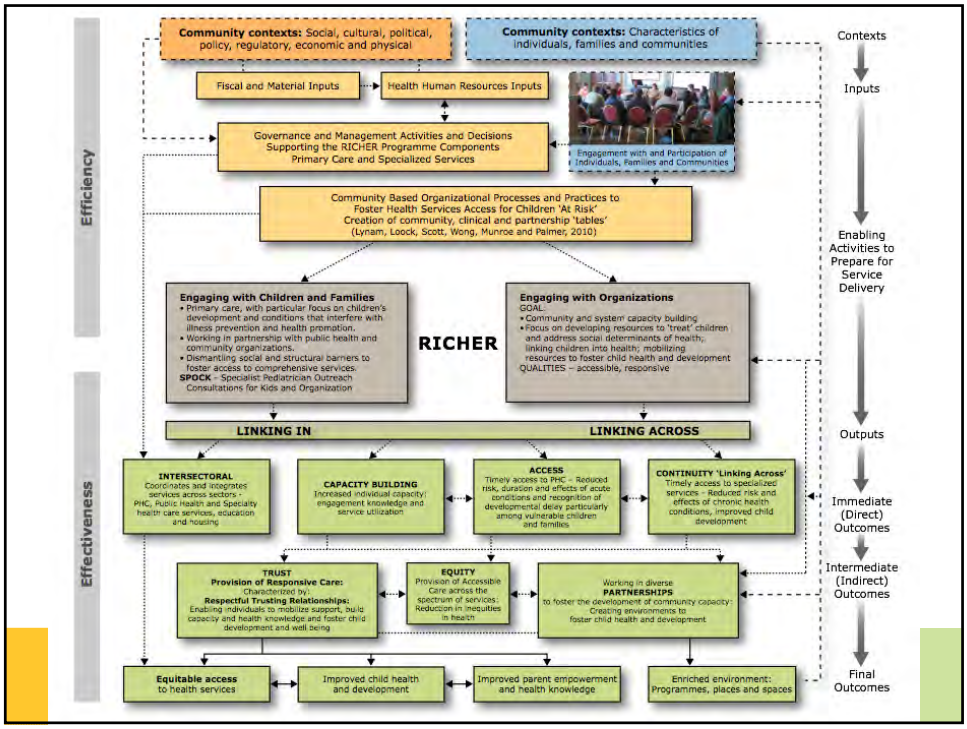

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Parent age, M (SD)	37.7 (9.4)
Single parent	**53.5%**
Missing	1.2%
Married or living with a partner	47.7%
Separated/Divorced/Widowed	23.3%
Never married	24.4%
Missing	4.7%
Did not complete secondary school or high school	26.7%
Completed secondary school or high school	23.3%
Had some university or completed college/post-secondary	30.2%
Completed bachelor's, graduate, or professional degree	16.3%
Missing	3.5%
Employed full-time	18.6%
Employed part-time	15.1%
Unemployed/ looking for work	12.8%
Looking after home/family	32.6%
At school/full-time education	3.5%
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Retired/other	2.3%
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White	23.3%
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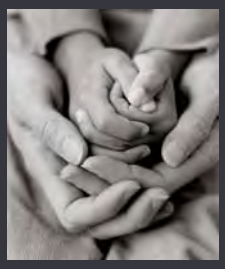

Characteristics of parent respondents (n=86)

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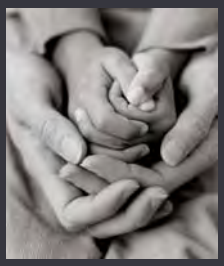

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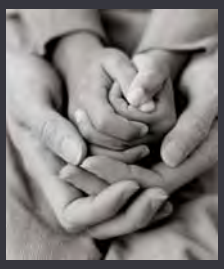

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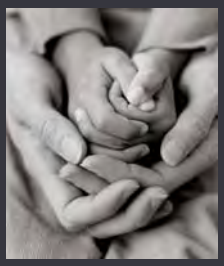

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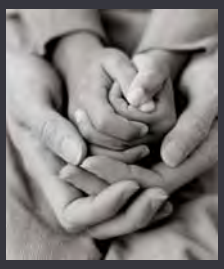

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Other language spoken at home	9.3%
1-2 person household	22.1%
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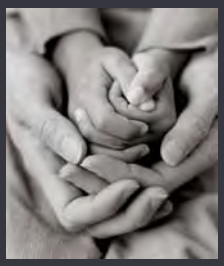
≥ 5 person household	32.6%
No children under 18 in household	4.7%
1 child under 18 in household	39.5%
2 children under 18 in household	29.1%
3 children under 18 in household	14.0%
≥ 4 children under 18 in household	12.8%
Less than $10,000 household income	25.6%
$10,000 - $30,000 household income	40.7%
$30,000 - $50,000 household income	11.6%
$50,000 - $80,000 household income	5.8%
More than $80.000 household income	3.5%
Apartment	50.0%
House	44.2%
Other (e.g. room, basement suite)	5.8%
Length of time in home, M (SD)	3.8 (3.3)
Rent home	81.4%
Own home	14.0%
Other	2.3%
Missing	2.3%
Receive financial support for housing	43.0%



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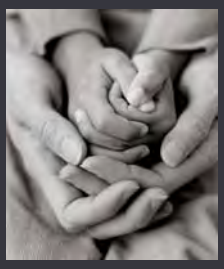

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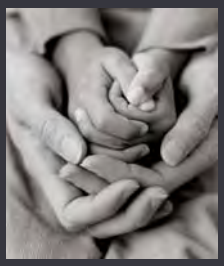

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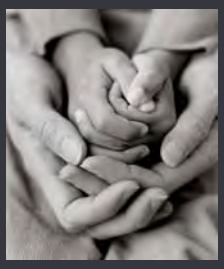

Characteristics of parents respondents (n=86)

Overall general health Excellent Good **Fair/Poor**	 51.2% 31.4% **17.4%**
Diagnosis of long-term or chronic health problems Don't know	23.3% 1.2%
For those with long-term or chronic health problem(s): **number of health problems**, M (SD)	1.5 (0.7)
For those with long-term or chronic health problem(s): Developmental (e.g. ADHD, autism, delayed speech) Congenital (e.g. Fetal Alcohol Syndrome, pigeon feet)	 45.0% 50.0%

Characteristics of children (n=86)

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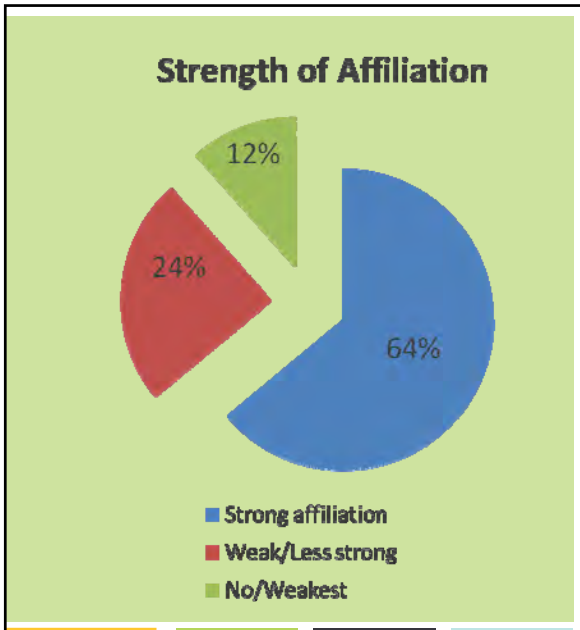
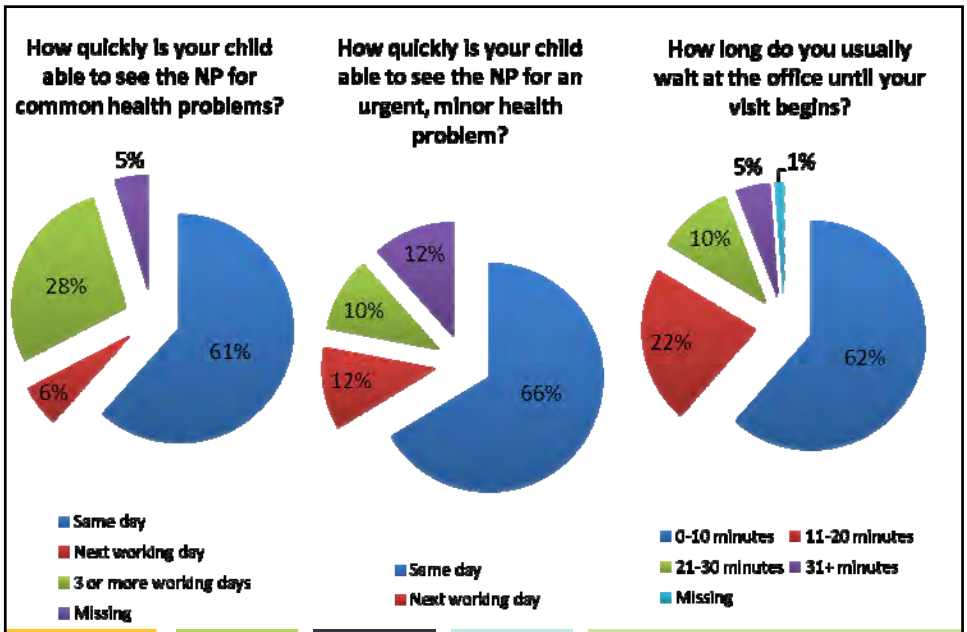


Experiences of Primary Care

Number of times used clinic in past 12 months:

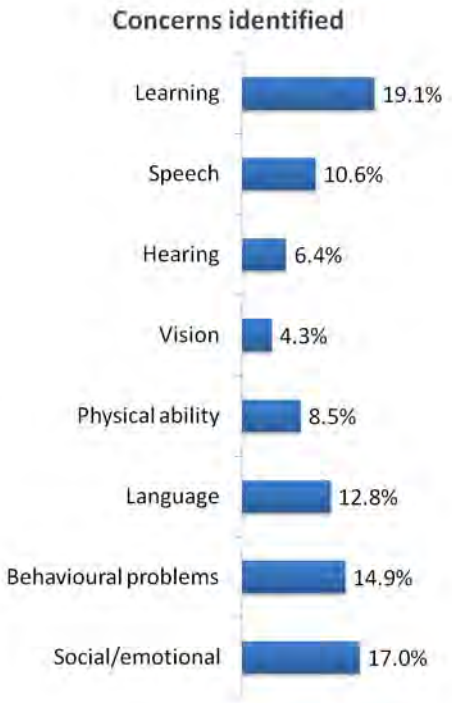
Mean 7.2
SD 10.5



Experiences of Primary Care

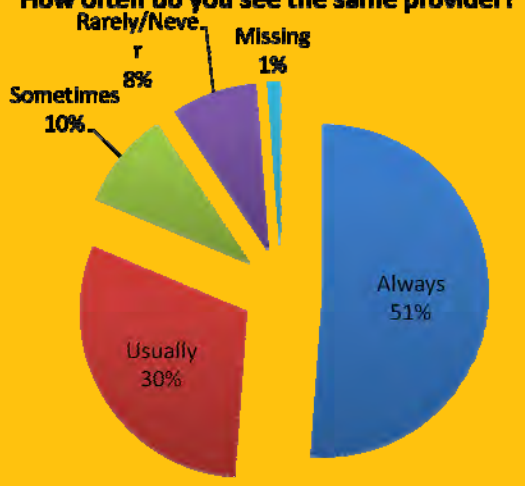
Experiences of SPI Clinic

Parents' perceptions of whether their child's development was assessed in last 12 months



Experiences of SPI Clinic

How often do you see the same provider?



NP knowledge of child (3 items)

Mean (SD)
3.9 (1.0)

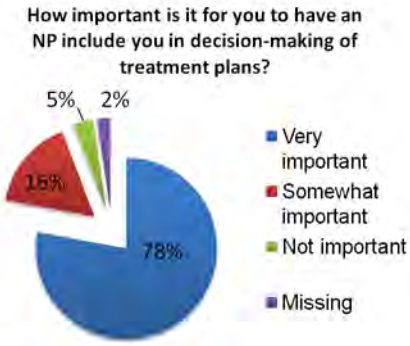
19.8% referred to development services

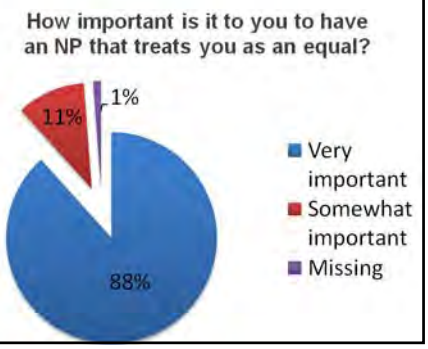
20.9% referred to supported child care (or having special needs)

27.9% had family meeting to establish care plan

Experiences of SPI Clinic

General clarity of communication scale, M (SD)	4.6 (0.6)
Explained results scale	**4.3 (0.9)**
Decision making scale	3.7 (1.3)
Compassionate, Respectful scale	4.7 (0.5)
Empowerment scale	**4.2 (0.9)**





What characteristics of providers' approaches to service delivery are associated with patient empowerment? (n=76)

Variable	N	%	Demographics & Experience (r^2= 0.47) Odds ratio	Overall p value/CI	Demographics & Experience Reduced Set (r^2= 0.36) Odds ratio	Overall p value/CI
Education				NS		
Did not complete high school or secondary school	22	30.6		0.27 (0.04, 2.00)		
Completed high school or secondary school	18	25		0.87 (0.07, 11.39)		
At least some college, university or post-secondary	32	44.4		(ref)		
Self-reported Ethnicity				NS		
White/Caucasian/European	15	20.8		(ref)		
Chinese	24	33.3		1.06 (0.06, 18.70)		
Aboriginal (First Nations/Metis)	21	29.2		5.55 (0.19, 161.60)		
Other	12	16.7		0.92 (0.04, 19.45)		
Strength of Affiliation				NS		
Scale range 0 to 4, treated as continuous				0.52 (0.13, 2.11)		
IPC Communication: Clarity of Communication				NS		
Scale range 3 to 5, treated as continuous				1.59 (0.43, 5.95)		
IPC Style: compassionate, respectful				<0.005		<0.0001
Scale range 2.67 to 5, treated as continuous				15.43 (2.58, 92.23)		34.52 (7.54, 157.93)
NP Knowledge of child				NS		
Scale range 1.67 to 5, treated as continuous				2.59 (0.83, 8.09)		

The PHC experience of clinician's **interpersonal style** is positively associated with patient **empowerment** ($p<0.01$).

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