IDENTITY AND RESPONSIBILITY: WHAT IT MEANS TO BE A CAREGIVER AND ITS IMPLICATIONS FOR POLICY AND HEALTH CARE

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Improving health care and quality of life for older adults in the U.S. requires increased attention to the informal caregivers supporting aging relatives. Studies estimate that over 40 million unpaid caregivers provide more than $400 billion of unpaid care; however, there is little research examining the scope and variety of support caregivers provide. Less research has examined how caregivers conceptualize their experience beyond “caregiver burden.” A more comprehensive understanding of the types of support caregivers provide and caregiver perceptions of their role and purpose are critical to enhancing policies, e.g., the Family and Medical Leave Act, to be more responsive to caregiver needs. This study seeks to (a) identify the ways informal caregivers provide support and (b) describe what it means to be a caregiver from the perspective of informal caregivers. We conducted four focus groups with informal caregivers (relatives or partners) in Southeastern Michigan (n=18) and conducted qualitative thematic analyses. Support that caregivers provide ranges from financial planning to medical decision-making to social engagement. While caregivers face frustration and isolation consistent with “caregiver burden,” they also recognize positive attributes of being a caregiver such as overcoming adversity and helping elderly relatives maintain dignity. These attributes contribute to their identity of what it means to be a caregiver and perceived capacity to improve their relative’s health. Our findings suggest that we are underestimating the scope of work involved in care-giving and that a wider range of activities should be considered when developing workplace policies and resources to promote caregiver wellness.

VALUE-BASED HEALTHCARE AS A FRAMEWORK OF CARE FOR OLDER ADULTS AND THEIR FAMILY CAREGIVERS

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Value-based healthcare (VBHC) is a term synonymous with the pursuit of greater value in healthcare, however, the term “value” lacks conceptual clarity. Using Porter’s 2010 seminal VBHC shows promise for placing the older adult and their family caregiver at the center of care models, which is a central tenet in healthcare value. The purpose of our study is to conceptualize how Porter’s VBHC is defined, operationalized, and implemented to address the need for person-and-family centered care models that improve outcomes while being cost effective. A literature search in six academic databases was conducted to identify articles examining VBHC; specifically studies with a Porter-based patient-centric focus. 1,001 articles were retrieved for initial review. Using a consensus-based logic model for inclusion/exclusion, 802 met the inclusion criteria for full text review. Articles were examined using the following objectives: 1) conceptually map the VBHC literature, 2) identify application of Porter’s equation, and 3) identify the methodologies used to measure outcomes, costs, and value. Findings were cross-compared and emergent themes organized to Porter facets of value (outcomes, costs, and value). Our review found the three facets of Porter’s VBHC are established across the literature, however, most studies examine only one or two facets and fail to specify or define all three. Although applied in research, there is a lack of consistency in the actual use of Porter’s definition. Five recommendations for future research using Porter’s VBHC include: (1) pre-selection of outcomes/costs, (2) operationalizing outcomes/costs, (3) value framework creation, (4) data collection, and (5) value calculation.

INTERNET USE, MENTAL HEALTH, SOCIAL SUPPORT, AND CARE BURDEN OF INFORMAL CAREGIVERS

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Given the psychological stress and health difficulties that stem from caregiver burden and lack of support, various technology-based supports have been introduced. This study aimed to understand the relationships of internet and social network use on informal caregivers’ health status, social support, and care burden. Outcomes were compared for three groups: Alzheimer’s caregivers (AC), other types of caregivers (OC), and non-caregivers (NC). A secondary data analysis of national data from the Health Information National Trends Survey 5-cycle for 2018 was conducted (N=3,297; NC=2,918, OC=443; AC=113). Using Stata SE 15.1, various statistical analyses (Chi-square, ANOVA, logistic regression) with jackknife bias correction were used to compare the 3 groups. In general, OC experienced the most serious depression/anxiety. More OC (32%) were diagnosed with depression/anxiety by health professionals than NC (22.64%) and AC (19.82%) (F(2,48)=5.58, p<.001). The Other Caregiver group also had higher scores in PHQ-4 (M=2.42, SD=3.07) than NC (M=1.75, SD=2.71) and AC (M=1.63, SD=2.42) (F(2,48)=3.97, p<.05). Regarding care burden, AC provided more support for their care recipients for ADLs (M=2.93, SD=1.65) and IADLs (M=3.75, SD=2.00) for AC than OC (F(1,49)=4.39, p<.05 for ADLs; F(1,49)=3.17, p<.10 for IADLs). OC (M=2.57, SD=2.43) and AC (2.96, SD=2.39) had fewer social supports than NC (M=3.41, SD=2.38) who can instantly assist them (F=11.60, p<.001), OC (21.68%) and AC (29.00%) more frequently than NC (12.01%) participated in social network (F(2,48)=5.72, p<.01) and online support groups (OC: 13.68%; AC:12.73%; NC:4.68%) (F(2,48)=9.84, p<.001). Developing practical online...