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Continuity of Care for Community-Dwelling Seniors

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Key Implications for Decision Makers

- This study is useful to decision makers wanting to measure continuity during the transition from hospital to homecare. Right now, there is no consistent, proven way to measure continuity of care in this area, even though the trend in Canada is to shorten hospital stays, leading to longer convalescence at home.
- Not only may attitudes and demeanour affect the flow of services and the perception of the flow of services, they may also affect quality of care and may indirectly influence health outcomes. Both caregivers and care receivers need to be sensitive to the possibility that their attitudes matter to health outcomes.
- Participants cited a variety of barriers to the personal actions they could take to ensure continuity of care. Patients mentioned their (or a family member's) poor health or difficulties with memory. Informal caregivers most frequently mentioned a lack of services or equipment for homecare. Case managers and hospital nurses most often mentioned system-related barriers such as lack of funding or scheduling and co-ordination, whereas community nurses most often said the barriers were a lack of time and a heavy workload.
- Clear definitions of each element of continuity need to be set out, because terms like “needs-based” care can mean very different things to formal care givers than they do to patients. Communication came up among patients and informal caregivers, who listed communication with doctors and care providers as ways they could ensure continuity of care.
- This study found no differences between rural and urban subjects in their concept of continuity of care. This means it appears that lack of access to health services by rural stakeholders has not changed their views of what is necessary to achieve continuity of care.

Executive Summary

Purpose

This study identified elements of continuity of care during the transition period from hospital to community, as identified by stakeholders.

Implications

Continuity of care is complex for seniors who convalesce at home following a brief stay in hospital. Because seven elements of continuity of care have been identified, and because there are significant differences as to what different stakeholders view as important, there is no single way to measure the essence of continuity of care in the hospital to homecare setting. Based on input from the interviewees and focus group participants, it is clear that most of the continuity-of-care elements have both subjective and objective aspects. This means it may be difficult to identify a single measure or standard for the smooth “flow” of services. What may be seen as continuous care by one patient may be seen as less than ideal by another. It is also clear that what the formal system calls “continuous care” may not be the same as what patients and/or informal caregivers would call it. This shows how important communication and information flow throughout the care process is, and how all stakeholder groups — including patients and informal caregivers — need to be involved in care planning and care delivery. In short, in an integrated healthcare system, both formal and informal stakeholders need to be actively involved.

Methodology

A total of 248 individuals participated in the study. Patients ranged in age from 65 to 89 years (Mean=72.70, sd=5.44; 23 males and 27 females). Informal caregivers ranged in age from 35 to 84 years. Hospital nurses, case managers, and community nurses were also interviewed. All participants were located in the same district health council region.

In phase one of the study, an exhaustive interview strategy was used. Initially, participants saw a picture of the flow of care from a stay in hospital to convalescence at

home. All subjects were asked what continuity of care meant to them — to explain the roles they felt they could play in helping continuity along, and to specify barriers, if any, that might prevent them from fulfilling these roles. In phase two of the study, the research literature was reviewed to determine whether measurements existed for the continuity of care elements identified in phase one. These measurements were adopted or modified for use, where possible. Where no measurement index could be found, an index was created. Following this, several focus groups gave feedback on the feasibility and validity of the suggested ways to measure continuity.

Results

Seven primary elements of continuity were identified by the five stakeholder groups: perception of good care, access to needs-based health services, stakeholder knowledge and communication, care provider attitudes and competency, consistency of care providers, uninterrupted delivery of care, and waiting time.

There were significant differences in how often the elements were mentioned. Patients and informal caregivers mentioned perception of good care, care provider attitudes, and waiting time more frequently than the case managers, community nurses, and hospital nurses. The latter stakeholder groups mentioned knowledge and communication, consistency of care providers, and uninterrupted delivery of care more frequently. Access to needs-based health services was mentioned often by all stakeholder groups. The informal stakeholders mentioned elements that were more subjective in nature, whereas the elements emphasized by the representatives from the formal system were more objective and system-based. After reviewing measurement literature and holding several focus groups, measurement indicators were developed for each element of continuity of care.

In response to the question “What kinds of action could you personally take to ensure continuity of care?”, both patients and informal caregivers listed communication with doctors and care providers. Patients also mentioned that they could be co-operative by complying with the care plan established by professionals and follow physicians’

recommendations. The most frequently mentioned theme by all formal care providers was communication, and the importance of ensuring accurate information was also stressed. In general, the actions mentioned by the informal stakeholders were more passive in nature.

Participants cited a variety of barriers to the personal actions they could take to ensure continuity of care. Patients mentioned their (or a family member's) poor health or difficulties with memory as a potential barrier. Informal caregivers most often stated that the barrier was lack of services or equipment for homecare. Case managers and hospital nurses most often mentioned system-related barriers such as lack of funding or scheduling and co-ordination, whereas community nurses most often said the barriers were a lack of time and a heavy workload.