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Consumers' Views of Coordination, Their Transition Experiences, and Health System Performance

by

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ABSTRACT

Restructuring health service organizations into vertically integrated systems is a national and international trend. In Alberta, a regional structure for the delivery of health services was introduced in June 1994. A major challenge in planning and evaluating services in a health care region is to first conceptualize the region as a system. "Systems thinking" requires an understanding of the links and interrelationships among different parts of the system, as well as its specific elements.

Coordination, which is one means of linking sectors, has been identified in the literature as a critical organizational attribute. Despite its importance, there are very few studies about coordination, and no previous empirical work that examines what coordination means to consumers, who are key stakeholders in the health care system.

In this qualitative, exploratory study, 33 consumers who experienced the transition from an acute care hospital into the Home Care Program of the Calgary Regional Health Authority were interviewed. They were asked to describe their transition experience and to identify what aspects of coordination were important to them. Interviews were recorded, and analyzed using constant comparison. The coding and retrieval of information was facilitated by the computer software program Nud*ist.

The present study is the first to identify what coordination means to consumers including terms and components. A very significant finding to emerge from the data is the crucial organizational role that consumers play in coordination. Five types of activities that consumers undertake as part of this coordination role are identified. The study also identifies what aspects of health care system support are important to consumers for preparation to return home, and identifies the elements of a successful transition between hospital and home. The study has produced the only model--grounded data from interviews with consumers--that proposes how coordination contributes to a successful transition.

These findings contribute to understanding and evaluating how to manage both the boundaries between sectors in a vertically integrated health care system, and the transition process for those who use the system. This information has significant implications for assessing the performance of integrated health care delivery systems.

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DEDICATION

To my family, past and present, for your love and encouragement.

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CHAPTER 1: THE RESEARCH PROBLEM

I. PURPOSE

The main purpose of this study is to develop a substantive grounded theory about the meaning of coordination to consumers who have experienced the transition from an acute care hospital into the Home Care Program of the Calgary Regional Health Authority. The findings provide a foundation for planning coordinated health services and for developing measures of regional health system performance that reflect the experiences of health care consumers.

II. RATIONALE

Health reform, which in many jurisdictions includes the restructuring of health service organizations, is a national (Health Canada, 1996) as well as an international trend (World Health Organization, 1996). Nine provinces in Canada have introduced some form of regionalized system for the provision of health services (Canadian College of Health Service Executives, 1997). There are numerous recommendations for the evaluation of regional or "devolved" systems (Angus et al., 1995; Canadian Medical Association, 1993; Ontario Premier's Council on Health, Well Being and Social

Justice, 1994). However, no comprehensive evaluations of the performance of these systems have yet been conducted (Health Canada, 1996; Lomas et al., 1997).

In Alberta, more than 200 hospital boards and hundreds of other boards (Alberta Health, 1994 b) have been consolidated into 17 regional health authorities, each with a single governance structure. However, bringing formerly independent organizations under one board does not necessarily produce the "integration of services and facilities in the health region" prescribed by the Regional Health Authorities Act (Province of Alberta, 1994). One way to actually accomplish the desired integration is to think of the region as a system. A system is a set of interrelated and interdependent parts that form a complex whole (Rakich et al., 1985 p. 158). Because of this interrelatedness, it is important to understand the relationships among different parts of the system, as well as to examine specific elements. The literature on integrated delivery systems (Coddington et al. 1996; Gilles et al., 1993; Shortell et al., 1993) provides a useful framework for conceptualizing a health region as a system, rather than merely a collection of health care organizations with a common board.

A key feature of a health region, which distinguishes it from a group of hospitals under common ownership, is vertical integration (Arndt, 1991; Brown et al., 1986; Leatt, et al. 1996). This is the integration of activities at different stages of the process of delivering patient services (Devers et al., 1994). This study examines

coordination between acute care and home care, which are different stages of the patient care continuum. The study will, therefore, contribute to understanding vertical integration which is a crucial aspect of regionalization (Ackerman, 1992; Ball, 1996; Conrad, 1993).

The current study focuses on the consumer's perspective. Consumers' experiences, as much as the technical quality of care, will affect how they use, benefit from, and evaluate the health care system (Gerteis et al., 1993). The importance of the consumer's perspective in evaluating organizational performance is evident in the balanced scorecard principles described by Kaplan and Norton (1992; 1993; 1996). This balanced scorecard approach can be used to assess the performance of hospitals (Baker and Pink, 1995) and, more recently, has been applied to assessing health care systems (Leggat and Leatt, 1997). The findings from the present study expand this balanced scorecard framework for assessing the performance of integrated delivery systems.

The present study examines the views of consumers about the coordination of care in their transition from an acute care hospital back into the community with Home Care support. This is an initial step in designing an evaluation tool to determine if the regional structure results in the consumer involvement and community-based care that was anticipated in the Regional Health Authorities Act (Alberta Health, 1994).

Coordination is an intended and anticipated outcome of the new regional health system in Alberta. : "The Regional Health Authorities act will promote coordination and integration of health services" (Alberta Health, 1994). Coordination is also a key element in organizational theory (Barnard, 1960; Galbraith, 1973; Whetten, 1981; Weiner, 1990) and in the health services literature (Bolland et al., 1994; Charns et al., 1993; Longest and Klingensmith, 1994). Yet, despite its prominence in the literature, there is very little empirical work examining the actual construct of coordination (Alter and Hage, 1993; Grusky and Tierney, 1989) and there are no models or theories of consumers' views about the coordination of health services. Therefore, an exploratory, qualitative study was conducted.

III. RESEARCH OBJECTIVES

The objectives of this research were:

1. to develop a substantive grounded theory about the meaning of coordination to consumers who have experienced the transition from an acute care hospital into the Home Care Program of the Calgary Regional Health Authority;

2. to describe elements that contribute to a successful transition between hospital care and Home Care; and

3. to explore whether consumers in the jurisdiction of the Calgary Regional Health Authority consider three concepts identified in the health services literature--access, comprehensiveness, and compatibility--to be related to, or important to, coordination.

CHAPTER 2: BACKGROUND

I. OVERVIEW OF THE CHAPTER

This chapter establishes the background of the study. The review opens with an introduction to health care reform and regionalization and is followed by a discussion of health care regions as systems. Since health care regions in Alberta exhibit many of the features of integrated delivery systems, the influential literature related to this topic is reviewed next.

Since there are numerous calls for the evaluation of the emerging regions, the next topic is assessing integrated delivery systems, with an emphasis on the balanced scorecard technique. A major issue in planning and evaluating health care regions is the challenge of conceptualizing the region as an organizational system, rather than a collection of hospitals and other facilities that share a common board. Therefore, the next section in this review introduces three constructs that are crucial in organizational systems: interdependence, integration, and coordination. The discussion about these constructs includes references to the classical organizational literature as well as recent work. The chapter concludes with comments on the relevance of the present study.

II. THE CONTEXT

A. HEALTH REFORM

Health care organizations and health systems have been described as "under siege" (Hannah, 1995) due to the conflicts between decreases in funding and simultaneous increases in consumer demands and expectations for new treatments, technologies, and programs. Across Canada a variety of commissions in the late 1980's and early 1990's have looked at the delivery of health services and recommended reform (Health Canada, 1996). The Canadian reports have a number of common themes, including concerns about inefficient organizational structures (Health Canada, 1996). Health care systems in other parts of the world are also under review (World Health Organization, 1996) and are grappling with the same challenges identified in the Canadian reports: cost containment, improved health outcomes, increased flexibility and responsiveness in the delivery of care, and better integration and coordination of services (Lomas, 1996).

In Alberta, the path to health care reform is marked by a series of influential documents from Alberta Health or the Province of Alberta. These documents include the Rainbow Report (Province of Alberta, 1989)--the report of the Premier's Commission on Future Health Care for Albertans; Partners in Health (Alberta Health, 1991)--the government's response to the Rainbow report; the reports from a series of Roundtables on Health (Alberta health, 1993); Starting Points (Alberta Health 1993)--

a follow-up to the Roundtables, which contains the initial plans for regionalization; and Health Goals for Alberta (Alberta Health, 1993), which includes a broad definition of health. This progression of documents culminated in the Regional Health Authorities Act (Province of Alberta, 1994) and a User's Guide for the Act (Alberta Health, 1994). The Regional Health Authorities Act establishes the health regions in Alberta. Seventeen geographic regions and 2 province wide health authorities (one for cancer services the other for mental health services) were announced. The Act identifies five areas of responsibility that the regional health authorities have for the population in their region: 1) protecting and promoting the health of the population; 2) assessing health needs; 3) determining priorities and allocating resources; 4) ensuring reasonable access to services; and 5) promoting "the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region."

"The reformed health system will be a reality when we can say, with evidence, that we have a wellness-based system that is consumer focussed, integrated, accessible, appropriate, and affordable" (Provincial Health Council of Alberta, 1996, p. 11).

B. REGIONALIZATION

Restructuring health service organizations into a regionalized system for delivering care (regionalization) is one aspect of health reform in many provinces.

Regionalization involves the transfer of greater control and decision-making for the delivery of health services from the provincial level to more local, regional health authorities. The degree of transfer lies on a continuum from deconcentration (the shift of some administrative structures and activities of the province to local offices) to decentralization (some authority transferred to the region) to devolution (significant decision-making and authority reside with the region) (Lomas, 1996). Alberta is at the devolution end of the spectrum, since it has transferred significant authority and financial responsibility to the regions. This decentralization continuum is only one dimension of regionalization. Carrothers et al. (1991) identify two other dimensions: 1) a geographic aspect to the distribution and control of services; and 2) the rationalization of services.

Regionalized health care systems often exhibit features of both centralization (transferring power from several units to one central location) as well as decentralization (power is transferred from a central location to smaller local units) (Canadian Medical Association, 1993). This is the case in Alberta. Decentralization is evident in the devolution of administrative and financial responsibility for public health, as well as acute, long term, and community care, from the province to regional boards. (Fee-for-service payments to physicians were not included in the regional funding envelope when the regions were established in 1994). Centralization is evident within the regions from the consolidation of the public health boards and the

institutional boards for acute and long term care into a single regional health authority board.

Regionalization is a nation-wide trend; nine of ten provinces in Canada have embarked on various forms of regionalized health care services (Canadian College of Health Service Executives, 1997). There are numerous recommendations for the evaluation of regional or "devolved" systems (Angus et al., 1995; Canadian Medical Association, 1993; Ontario Premier's Council on Health Well Being and Social Justice, 1994). So far, however, there have not been any comprehensive evaluations of the performance of these systems (Health Canada, 1996; Lomas et al., 1997; Ontario Premier's Council on Health Well Being and Social Justice, 1994).

C. HEALTH REGIONS AS SYSTEMS

Although the Alberta legislation brings together many organizations under a single regional governance structure, this restructuring does not guarantee that the newly created region will in fact operate as a health care system. Bertalanffy (1968) defines systems as "sets of elements standing in interaction" (p. 38). The intent of his general systems theory was to identify universal principles that are valid for systems in general. The significance of his work to this study is his emphasis on "wholeness", since "systems are not understandable by investigation of their respective parts in isolation" (p. 37).

An organizational system is a set of interdependent parts that relate to each other in the accomplishment of a common goal. The shift from a group of independent organizations to a health care system means that interdependencies and common goals must be emphasized (Devers et al., 1994) and performance measures must be redesigned to reflect this shift.

Shortell (1988) suggests that static structural characteristics alone, such as ownership, size, and location are inadequate for capturing the behavioural dynamics of system operations. Profiles are needed that are based on relational attributes that capture the behavioural interactions. These dynamic aspects related to "systemness" suggested by Shortell (1988) include commitment to having the following elements in common: culture; financial planning and control; strategic planning; human resource planning; decision and input support systems; quality assurance; and integration of structures and services. He predicted that one of the key elements for hospital systems to achieve success was vertical integration.

Vertical integration refers to coordinating, linking or incorporating within a single organization, activities or entities at different stages of a production process (Dowling, 1995). In health care, this is the process of producing and delivering care. Vertical integration can be forward toward an organization's market or backward toward the inputs of production (such as suppliers) (Conrad, 1993). Vertical

integration in health care is also considered to integrate forward and backward through the continuum of care (Gillies et al., 1993). If acute care is viewed as the core service, vertical integration could be backward to include preventative care or forward to include community-based rehabilitation.

The literature in the next section on integrated delivery systems provides a framework for conceptualizing and assessing a health region as a unified system rather than as a collection of previously autonomous organizations with a common board.

III. INTEGRATED DELIVERY SYSTEMS

A. TERMINOLOGY

An organized delivery system is "a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally responsible for the outcomes and the health status of the population served" (Shortell et al., 1993). This definition also describes a regional health authority in Alberta. Many authors use the above definition to describe an integrated delivery system and use the terms "organized delivery system" and "integrated delivery system" interchangeably (Pointer et al., 1995). Shortell and his colleagues (1996) "prefer the term organized delivery system to the more frequently used integrated delivery system because we believe integration is an end state that

few, if any current systems have achieved" (p. xiv preface). In the Canadian context, however, the term "integrated delivery system" is used (Ball, 1996; Leatt et al., 1996; Pink et al., 1996). Considering the Canadian literature, and since health regions in Alberta are directed to "support the integration of services and facilities in the health region"(Province of Alberta, 1994), in this document, the term "integrated delivery system" will generally be used. However, quotations from work using "organized delivery system" will follow the phrasing used by the authors of that work. The terms "organized delivery system" and "integrated delivery system" are considered to be synonymous in this text.

B. THE HEALTH SYSTEMS INTEGRATION STUDY

The Health Systems Integration Study was a landmark 4-year longitudinal study of 11 health care systems in the United States. As part of the study, Shortell and his colleagues identified barriers and facilitators to creating organized delivery systems (Shortell et al., 1993; Shortell et al., 1994). The results from the integration study, that are related to how to conceptualize and measure integration (Gillies et al., 1993) and using an integration scorecard to assess integration (Devers et al., 1994), are presented below.

1. Types of Integration

In the Health Systems Integration Study, Devers et al. (1994) described five types of

integration, which are listed below. Quantitative methods (counting the number of shared protocols, policies, etc.,) were used to measure the degree of integration achieved. Integration was reported either as a mean number or a mean percent (with the standard deviation and range) indicating how many protocols or features were shared between operating units in each system. The kinds of measures used to assess integration are listed below, together with the types of integration.

Functional Integration

This is the extent to which key support functions, such as financial management, human resources, information services, quality assurance/improvement, strategic planning, etc., are standardized (i.e., use the same policies, guidelines, etc.) across operating units. Functional integration was reported as the percentage of items that were standardized in eight functional areas including those listed above.

Physician Integration with the System

This was assessed in four areas: a) economic involvement (15 measures); b) administrative involvement (three measures); c) group practice formation (five measures); and d) shared accountability (five measures).

Horizontal Integration

This is the coordination of functions, activities, or operating units that are at the same

stage in the process of delivering services (e.g., consolidation of hospitals). It is part of clinical integration (see clinical integration below for the measures used).

Vertical Integration

This is the coordination of functions, activities, or operating units that are at different stages of the process involved in delivering patient services (such as acute care and community-based rehabilitation). Although organized delivery systems utilize horizontal integration strategies as well, vertical integration strategies are emphasized to differentiate them from multi-hospital systems or other chains providing services at a single stage of the delivery process. This is also part of clinical integration and the integration measures are described below.

Clinical Integration

This is the extent to which patient care services are coordinated across various functions, activities and operating units of a system. Clinical integration includes both vertical and horizontal integration. In the Health Systems Integration study, clinical integration was assessed across six major dimensions:

a) clinical protocol development - e.g., the percent of protocols shared with at least one other operating unit;

b) medical records uniformity - e.g., percent of medical record features shared;

c) clinical outcomes data collection - e.g., average number of 15 clinical outcomes (such as readmission after ambulatory surgery) that were shared by operating units;

d) clinical programming and planning - e.g., the percent of six program and planning tools (such as medical staff planning) that were used by system operating units;

e) shared clinical support services - e.g., percent of nine support services (such as laboratories) shared by at least one operating unit; and

f) shared clinical service lines - e.g., the percent of 10 clinical service lines (such as cardiology, oncology) shared with at least one operating unit.

The authors do not comment on the degree of clinical integration achieved by various systems but the numbers reported in the tables are low with a large range and large standard deviation. (See Appendix I.A.) The authors stress that the value of the integration score card is the process of developing it. The comments by Devers et al. (1994) suggest that the development, collection and feed back of system wide indicators can help systems explicitly examine the relationships between the operating units, as well as reconceptualize activities in system terms. In addition, the scorecard is a tool that is useful for tracking the progress of a health system toward achieving integration.

2. Measuring Integration

Whereas Devers et al. (1994) reported on measures that involved counting the number

of shared protocols etc., the analysis by Gilles et al. (1993) focused on the perceptions or judgements of people working in the system. This cross-sectional study examined integration along several dimensions using a self-administered questionnaire that was given to system and operating unit managers, selected board members, and selected physician leaders. The questionnaire measured perceived integration (functional, physician-system, and clinical), using a 54-item, 5-point Likert scale. With a 7-item Likert scale, respondents were also asked to rate "function effectiveness" in 10 areas, including strategic planning, financial and information systems, communication, etc. The study found statistically significant associations between various levels of functional integration, physician-system integration, and clinical integration. There was also a positive relationship reported between perceived integration and perceived effectiveness. Intuitively, one would expect to find this positive association between integration and effectiveness. However, one of the questions on the "function effectiveness" questionnaire was "Overall how much integration does your system have?" which makes the independence of these measures questionable. Reporting a relationship between perceived effectiveness and perceived integration would be more credible if the two measures were not related.

C. FRAMEWORKS FOR CONCEPTUALIZING REGIONAL SYSTEMS

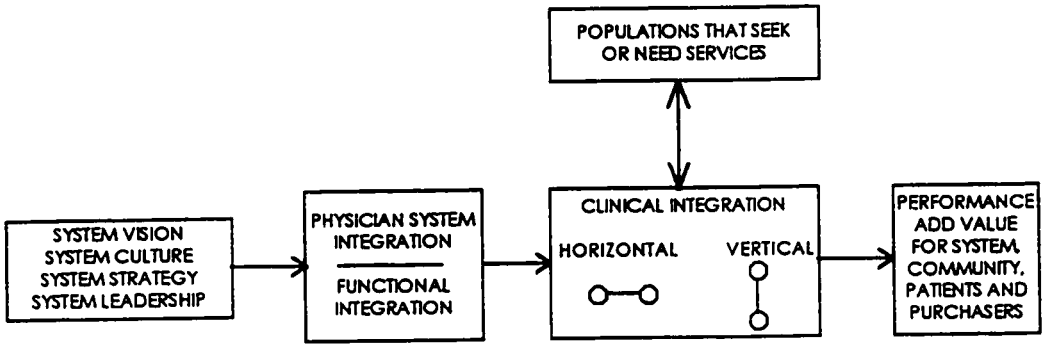
One of the challenges of visualizing a health care region as a system is to conceptualize how various aspects or activities in the region relate to each other. The

following two frameworks provide visual representations of the interactions between various parts of a health services system.

The first diagram (Figure 1) is an integration framework that identifies the way in which the various types of integration described by Devers in the preceding section relate to each other. However, unless one is familiar with the defintions of the various types of integration, it is not immediately clear how the diverse activities that take place in a health service organization are incorporated in the framework.

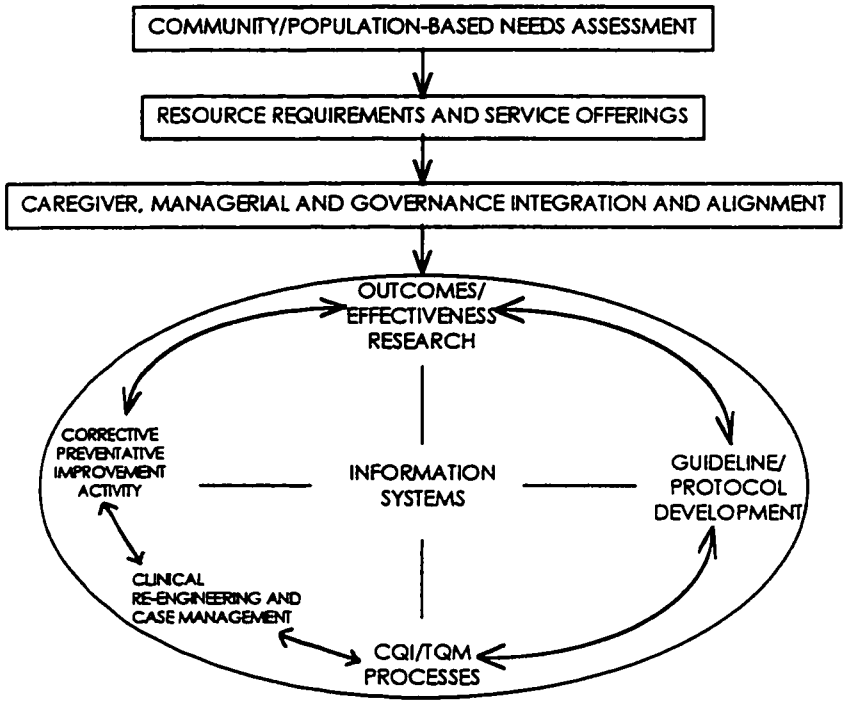
The Community Health Management System (Figure 2), contains many of the same elements as Figure 1, but the second framework actually identifies activities in a way that is more easily recognized by those working in a health system. For example, the Framework in Figure 2 identifies the way in which the internal organizational processes, such as Continuous Quality Improvement, relates to management and governance functions, which are in turn determined by the needs of the community or population that the health care system serves.

FIGURE 1
INTEGRATION FRAMEWORK
(from Gillies et al., 1993)



The above integration framework links the various types of integration defined in the preceding section. Strategic activities that need to be shared across all operating units in the system include a common vision, culture, strategic planning process, and leadership structure. These strategic activities need (and help to develop) functional integration and physician integration into the system. These three elements (strategic, functional, and physician integration) support both horizontal and vertical integration, which together constitute clinical integration. The health care services provided through clinical integration are in response to, and affect, the needs of the population that the system serves. Overall, integration should add value for its stakeholders.

FIGURE 2
THE COMMUNITY HEALTH CARE MANAGEMENT SYSTEM
(from Shortell et al., 1995)



The first task in the Community Health Care Management System is to assess the needs of the population to be served and identify the resources and services to meet those needs. The necessary caregiver, management, and governance structures are then set. The model also identifies how the internal organizational processes relate to the overall system. These internal processes require a continuous cycle involving the development of guidelines, the use of CQI/TQM processes, clinical re-engineering and improvement activities, with the evaluation of outcomes.

The community health care management system envisioned by Shortell and his colleagues (1995) describes what health care regions in Alberta are trying to achieve. In the most advanced stage of a Community Health Care Management System, acute inpatient care is no longer the "core" business of the system. Rather, primary care, disease prevention, and health promotion are the main focus or "core business". Acute care is still important but it becomes part of an integration strategy which provides the care needed to support the other preventative and primary care activities. The goal is to organize the entire continuum of care--from health promotion and disease prevention to primary, secondary and tertiary acute care, home care, and hospice care--to maximize effectiveness across episodes of care. A premium is placed on integration and holistic care. "The cumulative impact of these 'reinvention' processes is the emergence of a community (not just patient or enrollee) health care management system that takes seriously the responsibility for maintaining and enhancing the health status of populations". (Shortell et al., 1995, p. 150). This is consistent with the aims identified for the health care regions. (Alberta Health 1994). In particular, "the hospital no longer needs to be the centre of the health system" (Provincial Health Council of Alberta, 1996 p. 4).

In summary, the two models provide frameworks to link various aspects of health system activities. It is this linking of activities that is crucial for the development of regions into health care systems.

IV. ASSESSING INTEGRATED DELIVERY SYSTEMS

Although the evaluation of clinical integration is addressed in the previous section, a comprehensive assessment of integrated delivery systems requires a broader look at organizational effectiveness. A number of aspects related to the assessment of performance are reviewed in the next section. These include: how organizations are viewed which is related to how performance is measured, stakeholders, the technical issues of what to measure, and finally the balanced scorecard, which is a comprehensive framework that accommodates a variety of approaches and techniques.

Some authors depict organizational effectiveness as a subcategory of organizational performance (Flood et al., 1994). Others view organizational performance as the broadest domain with performance as a subset (Venkatraman et al., 1986). In this discussion, the approach suggested by Kanter & Brinkerhoff (1981) will be used - "look for all related measurement issues and use both effectiveness and performance as general and interchangeable terms" (p. 322).

A. APPROACHES TO ORGANIZATIONS

Cameron and Whetten (1983) conclude that understanding organizational effectiveness requires an understanding of multiple models of what organizations are. Scott (1992) conceptualizes organizations as rational, natural, or open systems and suggests how effectiveness is defined depends on how the organization is defined.

1. Rational Systems

In considering organizations as rational systems "organizations are collectives oriented to the pursuit of relatively specific goals and exhibiting relatively highly formalized social structures" (Scott, 1992 p. 23). This rational system definition identifies distinctive characteristics and focuses on normative structures. If organizations are viewed as rational systems, the attainment of "output" goals is the main criterion for effectiveness (Scott, 1992). A criticism of this approach is that organizations may have many goals that can be inconsistent, contradictory, or incoherent (Kanter et al., 1981).

2. Natural Systems

In the natural systems model, "organizations are collectives whose participants share a common interest in the survival of the system and who engage in collective activities, informally structured, to secure this end" (Scott, 1992, p. 25). In this approach, support goals are added to rational goals. This definition moves beyond the formal structures paramount in the rational system approach and introduces the informal or human elements of organizational life. In this approach, measures of effectiveness would include measures of participant satisfaction.

3. Open Systems

From an open-systems perspective, "organizations are systems of interdependent activities linking shifting coalitions of participants; the systems are embedded in (dependent on continuing exchanges with and constituted by) the environments in which they operate" (Scott, 1992 p. 25). In the open system approach, interdependence is stressed and connections with the environment are critical. The open systems perspective views organizations as highly interdependent with their environment, with effectiveness defined as adaption to the environment. One way to assess this would be the organization's success at obtaining resources from the external environment.

4. Open Versus Closed Systems

A closed system is self-contained and is completely predictable if its inner workings are understood. Both the "rational" and "natural" system approach are in the "closed" system tradition. They both view an organization as a stable system, separate from its environment, and they differ in their focus on structures versus participants.

In contrast, an open system is in a dynamic interaction with its environment; therefore it receives from and gives to the environment (Rakich et al., 1985). One of the most important characteristics of open systems is that they have a "nesting" quality, that is, systems are made up of subsystems and in turn are themselves contained within

larger systems (Weiner, 1990). Rather than using a dichotomy of open versus closed, it is more useful to think of systems in terms of the degree to which they are open or closed (Johnson et al., 1973).

B. STAKEHOLDERS

Kanter and Brinkerhoff (1981) point out that the dimensions of performance and effectiveness that are measured, and how they are measured, are in large part a function of who is asking the questions and how they wish to use the data. Thus, for a comprehensive assessment, a multiple stakeholder approach to effectiveness is warranted. Stakeholders are individuals or groups who have a stake in the decisions and actions of the organization and may attempt to influence those decisions and actions (Blair et al., 1990). An organization does not choose its own stakeholders. Rather, stakeholders choose to have particular stakes in the organization's decisions (Savage et al., 1997). The present study contributes to understanding the views of a key stakeholder, the consumer.

C. WHAT TO MEASURE

Another aspect of assessing effectiveness is deciding on the technical issue of what to measure. Donabedian (1987) described a trilogy for assessing the quality of care provided: structure (the attributes of the setting); process (what is actually done); and outcome (the effect or result). Structures and processes provide a foundation for both

achieving and understanding desired outcomes (Donabedian, 1988).

Flood et al. (1994) suggest that these same categories of structure, process, and outcome are also useful for evaluating organizational activities. Structural measures focus on the capacity for effective work and might include the qualifications and numbers of staff or the equipment available. Process measures are based on evidence of activities related to carrying out work. Examples include the process for granting and reviewing admitting privileges for the medical staff or reviewing the system for reporting the results of urgent laboratory tests. Outcome measures focus on changes produced and results achieved. For example, to assess clinical care one might look at the change in the health status of the patient and the patient's satisfaction with care. The three types of measures are linked. It is important to understand not only what happened (an outcome measure) but how it happened. This requires structural and process measures that may actually be more useful in making management decisions.

D. THE BALANCED SCORECARD

The balanced scorecard is a framework that accommodates all the approaches and techniques described above. Kaplan and Norton (1992) developed a balanced scorecard for assessing organizational performance. The scorecard augments the traditional financial measures of performance with three other perspectives: a) customers (i.e., stakeholders); b) internal business processes (i.e., a natural system

approach); and c) learning and growth (i.e., an open systems approach). The scorecard's measures may be related to structure, process and/or outcomes. The key feature of choosing measures is that they must be grounded in the organization's strategic objectives. By requiring managers to select a limited number of critical indicators in the four perspectives, the scorecard helps to focus the strategic vision (Kaplan and Norton, 1993) and helps an organization to link its long term strategy with its short term actions (Kaplan and Norton, 1996).

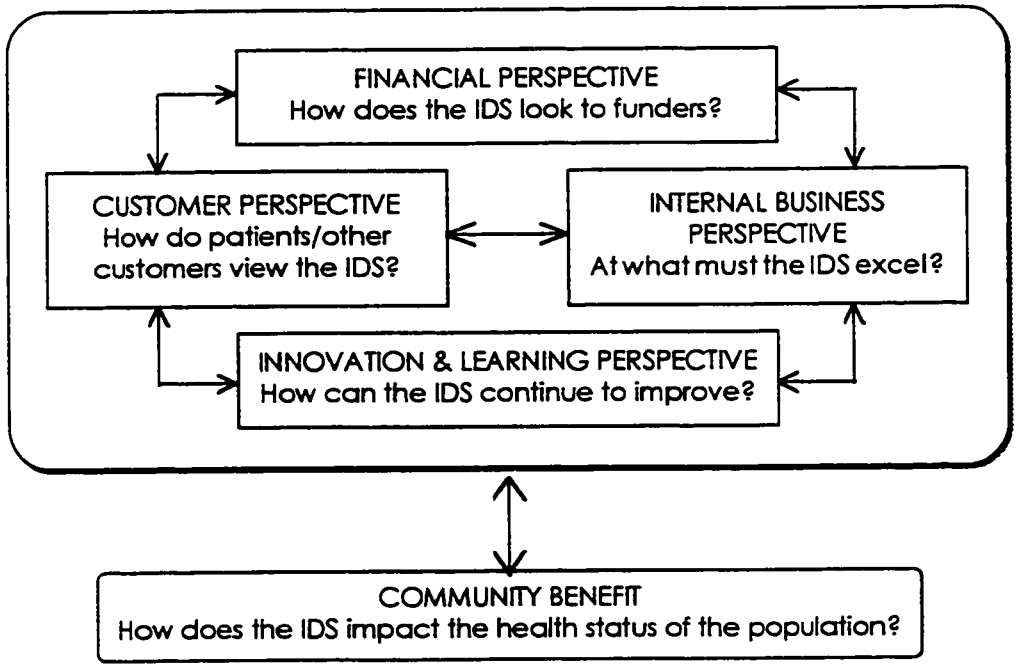
Baker and Pink (1995) applied the scorecard approach to Canadian hospitals and suggested that the technique could be used to answer four basic questions:

1. The Customer Perspective--How do customers see us?
    - An example of a measure is a patient satisfaction survey.
2. The Internal Business Perspective--What must we excel at?
    - The measures should relate to process--e.g., utilization or cycle time, AND outcomes e.g., patient's health status.
3. Innovation and Learning Perspective--Can we continue to improve?
    - An example of a measure is relevant employee training.
4. Financial perspective--How do we look to funders?
    - Measures might include the average cost per weighted case.

Baker and Pink (1995) suggest that feedback from measures in each of these four areas could provide a balanced view of a health care organization's performance.

Leggat and Leatt (1997) modified the approach still further. They recommend their framework for monitoring the performance of a strategic alliance for assessing integrated delivery systems (See Figure 3). Since an integrated delivery system includes accountability for the health status of a defined population, these authors added a community perspective as a fifth evaluation component in addition to the four identified by Kaplan and Norton, and Baker and Pink discussed above.

FIGURE 3
A FRAMEWORK FOR MONITORING THE PERFORMANCE OF A STRATEGIC ALLIANCE
(from Leggat and Leatt 1997)



IDS = Integrated Delivery System

Leggat and Leatt (1997) identify performance criteria for each of the five scorecard perspectives identified in the model (see Appendix I.B.). The performance criteria include measures that reflect all of the organizational approaches discussed in the previous section, as well as structure, process and outcome measures.

Cameron (1980) observes that increasing organizational effectiveness from the perspective of one constituency may result in a perception of lower effectiveness from another constituency. The framework encourages the choice of performance criteria and measures from multiple perspectives. With this pluralistic approach, the inherent tradeoffs that may be required in assessing organizational performance can be explicitly identified.

V. SYSTEM CONSTRUCTS

The preceding sections have reviewed the health services literature to establish a framework for conceptualizing and evaluating a health care region in Alberta as an integrated delivery system. This section reviews constructs in the organizational literature that are particularly germane to organizational systems and the key processes in these systems, including interdependence, integration, and coordination.

A. INTERDEPENDENCE

Health care organizations exhibit a high degree of interdependence (Longest, 1990). In addition to the interdependence that exists within a single organization (for example, a patient may require services involving a number of health care providers and hospital departments such as emergency, admissions, the laboratory, and a hospital ward), there is also interdependence with external stakeholders (such as funding agencies and the community) and other organizations (such as hospital suppliers).

In Calgary, seven health care organizations (including the acute care hospitals) all of which were previously autonomous with their own boards and management structures, have been consolidated under a single regional health authority with a single board and a single senior management structure. Although there is a common administrative structure for senior levels of management, interdependencies between sectors in the region must still be managed.

In his classic text, Thompson (1967) identified three forms of interdependence: pooled--each part renders a discrete contribution and the work performed is interrelated only in that each contributes to the whole; sequential--some activities must be performed before others; and reciprocal--interdependence goes in both directions and activities relate to each other both as inputs and outputs.

It is this last and most intense form of interdependence that is occurring in the Calgary health region. An example of this reciprocal interdependence is the relationship between the two operational sectors in the Calgary Regional Health Authority. Acute care hospitals need the Home Care provided by Community Services to allow early discharge of patients; in turn, Home Care receives the majority of its clients from the hospitals. Each sector must take the other into account--for example, appropriate preparation is required for both patients and health care professionals at both the acute care site and in the home to allow earlier discharge from hospital.

The type of interdependency affects the coordination required. Thompson argued that the greater the degree of interdependence, the more resources must be devoted to coordination. Social systems, which is how organizations are viewed (Baker, 1992), are among the most complex types of systems (Kast et al., 1974). This means the nature of the various flows both among system elements and between the system and its environment becomes more important (Scott, 1992). This in turn increases interdependence between system elements which increases the need for coordination (Thompson, 1967). In highly interdependent health care organizations, coordination among different groups of providers, and between providers and support services, encompasses critical interconnections in the delivery of care. How well these are addressed contributes directly to organizational performance (Longest et al., 1994).

B. INTEGRATION AND COORDINATION

In this study coordination and integration are considered to be related but distinct concepts. Integration is an organizational attribute; it relates to the linkages between differentiated, interdependent elements of the organization (for example, between two sectors). Coordination is one mechanism for achieving organizational integration and in this study it relates to the synchronization of services provided to the consumer in the transition from hospital to Home Care. That is, the focus of integration is the organization, and the focus of coordination is the consumer and the services that he or she receives.

The two concepts are interdependent. Coordination of services contributes to organizational integration (Conrad, 1993), together with other mechanisms, such as a common information system (Devers et al., 1994). In turn, the aim of integration is to enhance the coordination of services (Conrad and Dowling, 1990). This close relationship is consistent with a systems approach which assumes that an organization is composed of interdependent parts. This is also consistent with the health services literature on integrated delivery systems. For example, clinical integration is defined as "the extent to which patient care services are coordinated across various functions, activities and operating units of a system" (Gilles et al,. 1993). Thus coordination is related to patient services and integration is the system attribute that this coordination of services is intended to achieve.

C. INTEGRATION

To explain integration, it is first necessary to consider differentiation. In their classic work, Lawrence and Lorsch (1967) define differentiation as the state of segmentation of the organizational system into subsystems, each of which tends to develop particular attributes in relation to the requirements posed by its relevant environment. Vertical differentiation establishes the hierarchy and the number of levels in the organization, such as the CEO, vice presidents, and department heads. Horizontal differentiation is used to separate activities and in a hospital is reflected in departments such as diagnostic imaging, surgery, or food services (Kast et al., 1974). In contrast, integration is the process of achieving unity of effort among the various subsystems in the accomplishment of the organization's task (Lawrence et al., 1967). The integration may be vertical (between hierarchical levels) or horizontal (between departments) (Kast et al., 1974). Lawrence and Lorsch note that differentiation and integration are essentially antagonistic but provide clues as to how it might be possible to achieve high differentiation and high integration simultaneously (for example, the use of integrative subsystems that span the other subsystems).

These concepts are directly relevant to the Calgary Regional Health Authority (CRHA). There is differentiation into sectors and the need to integrate activities across these sectors. In the CRHA the "System Infrastructure Services Team" serves as one of the "integrative subsystems" promoted by Lawrence and Lorsch.

There is the potential for confusion in defining vertical and horizontal integration in the context of the CRHA. If acute care and community care are considered different "departments" within a single organization, then their linkage could be considered to be horizontal integration. However, to be consistent with the literature on regionalization and organized delivery systems, acute care and Home Care are considered to be at different stages of the patient care continuum and, therefore, in this study linkages between them are considered to be vertical integration.

D. COORDINATION

1. Historical View

One way of linking together the various parts of an organization (or of linking organizations) and managing interdependence is through coordination. Coordination "is conscious activity aimed at achieving unity and harmony of effort in pursuit of shared objectives within an organization or among a set of organizations participating in a multi-organizational arrangement of some kind" (Longest and Klingensmith, 1994). Scott's (1992) approach to organizations as rational, natural, or open systems, provides a useful framework for considering how views about coordination are shaped by different views of what an organization is. Coordination is an important thread evident in all three approaches, but coordination mechanisms differ with the various perspectives.

The rational, mechanistic approach to organizations emphasizes normative structures to achieve coordination. This is evident in the approaches that suggest achieving coordination using central authority, such as Litterer's (1973) "hierarchical coordination". The CRHA organizational structure of a single board and a single senior management group reflects an application of this strategy.

Where the rational system perspective stresses the normative structure of organizations, the natural system model places more emphasis on the behavioural structure (i.e., the characteristics of the participants in the organization). The coordination approaches that use formalized procedures are in this mode, for example Mintzberg's (1983) "standardization of work processes and skills". Hospitals that use a care map for managing routine procedures are in this category.

The open systems view of organizations stresses the complexity and variability of the separate parts, both individuals and groups, as well as the looseness of connections among them. Coordination mechanisms that reflect this view focus on outcomes. An example is Mintzberg's (1983) "standardization of outputs". In these approaches, the product or objectives are set, but the process of how to achieve these is determined by individuals or small groups of workers. This approach is consistent with the interest in managing outcomes evident in health care (Harrigan, 1992; Lohr, 1988).

Another coordination mechanism that reflects an open systems approach is the use of groups such as Van de Ven et al.'s (1976) "personal groups". Using total quality management teams to deal with quality of care issues (Harrigan, 1992) is an example of this approach in health care.

In addition to the approaches noted above, Scott (1992) also describes a mechanism of micro-coordination in which the task object is drawn into monitoring and guiding the services it receives. For example, universities involve students in ensuring that graduation requirements are met. This is especially relevant to the present study since it is the consumer's view about what is important in coordination that is the focus of the research.

Lawrence and Lorsch (1967) coined the term "contingency theory", which suggests that system design decisions depend on (i.e., are contingent upon) environmental conditions. Longest and Klingensmith (1994) point out that the mechanisms of coordination are diverse and achieve different levels of success depending on the characteristics of specific situations. This contingency view of coordination means that no single coordinating mechanism is best for all situations.

2. Recent Work

The two works in the recent literature that relate most directly to this study are that of Alter and Hage (1993)--because some aspects of their conceptual framework related to coordination will be examined in this study; and that of Grusky and Tierney (1989)--because they solicited the views of consumers about the coordination of services.

One of the "kinds of coordination" described by Alter and Hague (1993) is coordination as a performance objective or a program goal. Purposes of coordination are identified for system elements, which include programs / occupations, resources, and consumers. Three performance objectives of coordination (comprehensiveness, accessibility, and compatibility) are identified for each element. The performance objectives identified for consumers are as follows: for comprehensiveness--the individual consumer's needs are met; for accessibility--the individual consumer has access; and for compatibility--the individual consumer is treated consistently by different parts of the system. Thus, coordination is defined as the articulation of elements in a service delivery system (programs, resources, and consumers) so that comprehensiveness, accessibility, and compatibility are maximized.

Alter and Hage conducted an exploratory study involving two contiguous urban counties in the Midwestern United States and looked at 15 service networks in these

counties. They examined a number of aspects related to methods of coordination but there is no empirical work in their text related to coordination as a performance objective. As part of this study, consumers were asked if they considered these three performance objectives (comprehensiveness, accessibility, and compatibility) to be related to, or important to, coordination.

Grusky and Tierney (1989) evaluated the effectiveness of eight mental health care systems by collecting data from service organization directors, case managers, chronically mentally ill clients, and family members. One of the four measures of effectiveness used was a six-item coordination scale. (see Appendix I.C.).

VI. RELEVANCE OF THIS STUDY

This research develops a theory, grounded in data from interviews, about a key stakeholder's (the consumer's) views concerning a crucial system attribute (coordination). There are many calls to evaluate health care regions that are striving to become integrated delivery systems. A framework to evaluate the performance of these systems is the balanced scorecard, which considers that the consumer's perspective is a key part of an evaluation strategy. Involving patients in the assessment of care is not a new idea--patient satisfaction with clinical care is increasingly considered as an outcome in its own right (Harrigan, 1992). This study,

however, is unique in consulting consumers about their views of a construct that is related to the system itself --coordination.

There are no other empirical studies that examine what coordination means to consumers. Devers et al. (1994) count the numbers of shared protocols as a measure of coordination. Gilles (1993) asked managers about their views of effectiveness but did not interview consumers. Grusky and Tierney (1989) asked consumers about administrative measures that the authors had decided were important, but there is no evidence that consumers agreed that these were valid measures of coordination.

The results from this study can be useful in the short term for planning programs and services. An important future use is as a foundation for developing a valid assessment of the consumer's experience of coordination as one measure of the performance of an integrated health services delivery system.

CHAPTER 3: RESEARCH DESIGN AND METHODS

I. DESIGN

The present study uses a qualitative design. Qualitative research involves the collection, integration and synthesis of non-numerical narrative data (Leasure et al, 1995). The appropriateness of the qualitative approach is derived from the nature of the social phenomenona to be explored (Morgan et al., 1980). Qualitative methods are characterized by the search for meaning in particular settings in which human beings are considered active forces (Jones, 1988).

The research problem in this study is consistent with the criteria suggested by Creswell (1994) for qualitative research. It is exploratory research, the variables are unknown, the context is important, and there is no established theory base for generating hypotheses that could be tested quantitatively.

This study is based on the "constructivism" paradigm described by Guba and Lincoln (1994) which has the following assumptions:

1. There are multiple realities that are socially constructed, which may be more or less informed (in contrast to "proving the truth"). In this study, the reality that is examined is that of the consumer of health services.

2. The investigator and the participants are interactively linked so the findings are literally created as the investigation proceeds.
3. The study is naturalistic (in the natural world) rather than experimental.

Creswell (1998) describes five traditions in qualitative research. The approach used in this study is grounded theory, which develops theory grounded in data that are systematically gathered and analyzed (Strauss et al., 1994). This is in contrast to "grand theory", which is generated from logical assumptions and speculations about the "oughts" of social life. (Glaser et al., 1967). A grounded theory is one that is inductively derived from the study of the phenomenon it represents.

Glaser and Strauss (1967) identify two kinds of grounded theory that might be developed: Substantive Theory and Formal Theory. This study generates a Substantive Grounded Theory. Substantive Theory is developed for an empirical area of inquiry, such as patient care, professional education, etc., which is more specific than Formal Theory. Formal Theory is developed for a conceptual area of inquiry such as stigma, socialization, etc., which is much broader and may draw on a comparative analysis among numerous substantive cases.

II. PARTICIPANTS

A. DESCRIPTION

The informants for this study were consumers who had experienced the transition from an acute care hospital in Calgary into the short-term Home Care Program.

Short-term Home Care clients were chosen for the following reasons:

1. They are an important group of Home Care clients. The short-term clients make up about 20% of the total number of clients, but account for more than 50% of professional Home Care Services.
2. One rationale for regionalization is to shift the site of care from hospital into the community. The clients in short-term Home Care are the group that are most likely to reflect this change.
3. Across Canada, the length of time that people stay in hospital is decreasing (Canadian College of Health Service Executives, 1995). The short-term clients are the Home Care population most likely to include the patients that have experienced "early" or "timely" discharge from hospital.

All consumers who were capable of being interviewed and were referred to the designated Home Care team for short-term Home Care services from any hospital in Calgary were eligible for the study. There was no selection of participants related to their diagnosis or the type of care they received in hospital or at home.

B. DELIMITATIONS

1. The study was limited to those consumers who were willing and able to be personally interviewed. There may be issues related to consumers who do not speak English, or who are cognitively impaired, that will not be explored in this study.

2. This study investigates the consumer's perspective, it does not attempt to capture the family's experience or perspective In some instances, family members were present for the interview but they merely assisted the consumer to articulate or remember details of the consumer's experience. If a family member were present during the interview, care was taken to maintain the focus on the consumer's views.

III. SETTING

A. CALGARY REGIONAL HEALTH AUTHORITY

The setting for the study was the Calgary Regional Health Authority (CRHA). The CRHA is one of 17 Regional Health Authorities created through legislation in Alberta in 1994. The region has a single regional board (replacing seven previous boards), one regional medical staff structure, and one regional senior management structure with a single chief executive officer.

During the course of the study a number of organizational changes took place in the region. Initially there were six sectors or business units. There were four (vertical)

role sectors, each with its own chief operating officer, to provide clinical services: two for acute care; one for continuing care; and one for public health. Two (horizontal) business units (Support Services and Programs) meshed with the four clinical role sectors to form a matrix (Saunders, 1995). In July 1995 acute care was consolidated into a single sector (CRHA, June 1995). In April 1997 there was further consolidation of the sectors that provide clinical services into two operational sectors: (1) Acute Care and (2) Community and Continuing Care. Four region-wide sectors (replacing the two previous horizontal sectors) were introduced at that time: System Performance and Development; Population Health; Clinical Affairs; and Infrastructure Services (CRHA, October 1996).

The organizational change with the most direct consequence for the study occurred in April 1996, which was during the time period when the interviews were being conducted for this study. At that time, Home Care moved from the Public Health Sector to the Continuing Care Sector (CRHA, February 1996). Subsequently these two sectors were merged into one--the Continuing and Community Care Sector. The hospitals and Home Care are still in different sectors--Acute Care, and Continuing and Community Care--so the study is still relevant to coordination between sectors and vertical integration in a regional system.

B. HOME CARE

The Home Care Program "...enables people to live independently in the community. Services provided are sensitive to the assessed needs of the individual with the goal of maximizing control and responsibility for the individual and family". (Calgary Health Services, 1994)

Home Care has four client groups which are described below (Calgary Health Services, 1994) with an active daily case load in May 1995 of about 5000 people. (Source: Home Care Information System, May 1995)

1. Short-term Care (about 20%): Clients requiring care for less than 90 days.
2. Long-Term Care (about 70%): Clients requiring care for more than 90 days.
3. Palliative Care (about 10%): Clients for whom a cure is not anticipated, who wish to remain at home for as long as possible and may choose to die at home.
4. Pediatric Care (<1%): Children under 18 years of age who receive short-term, long-term, or palliative care.

C. SITE ACCESS

Permission to work in the Calgary Region was obtained from the Chief Executive Officer of the CRHA in January 1995. Permission to work with Home Care was obtained from the Chief Operating Officer of Public Health for the CRHA in February 1995. In May and June of 1995 there were a series of meetings with Home

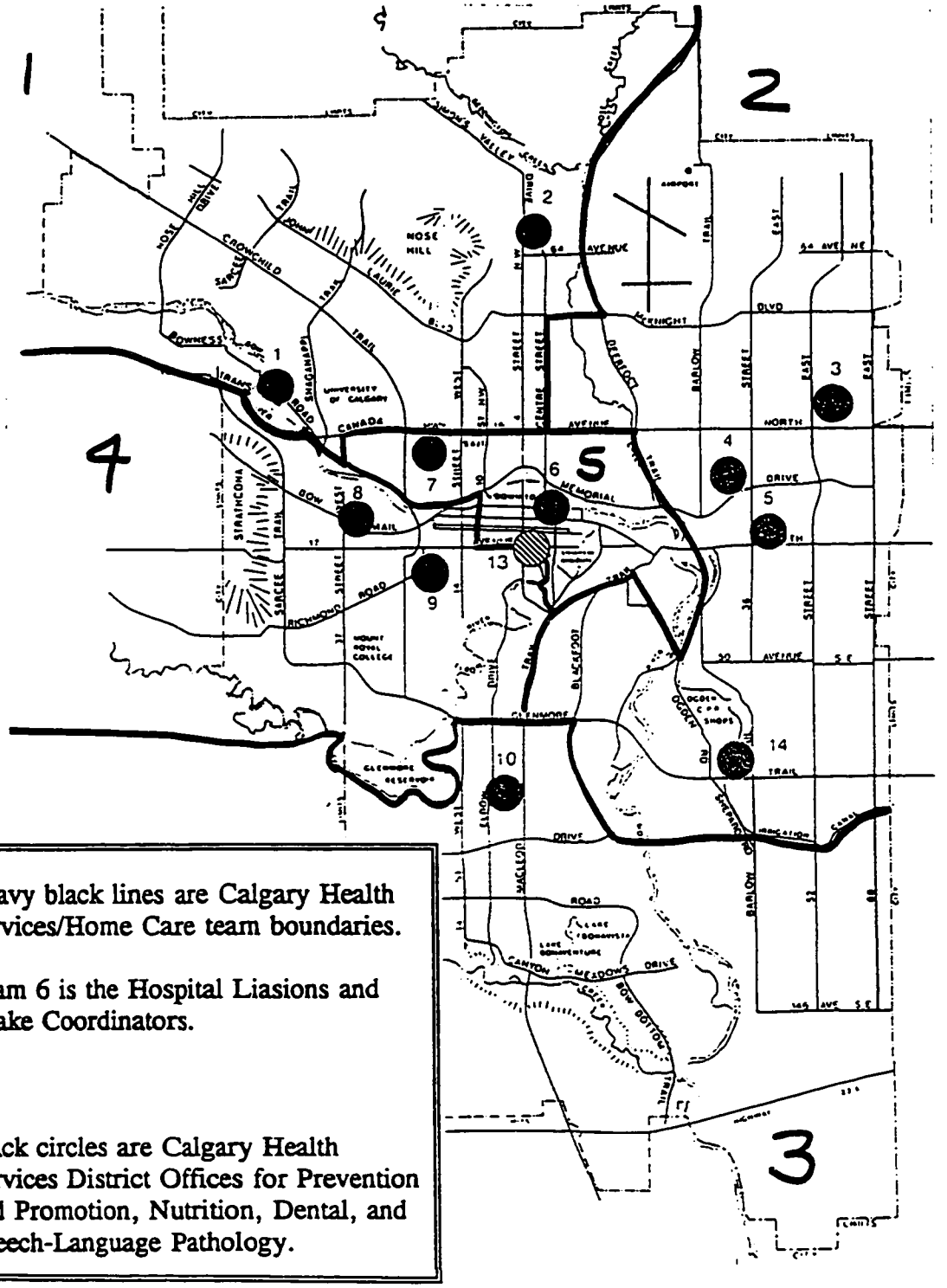
Care mangers to discuss the study and develop a protocol for the study (see Appendix I. A. 1. Home Care Workflow Plan).

IV. DATA COLLECTION

A. RECRUITMENT

There are six geographical areas in the CRHA identified for the provision of Home Care Services, and each area has a Home Care "Team" assigned to it (see Figure 4). There are a total of seven Home Care Teams because one team (Team 6) is the Hospital Liaison and Intake Coordinators. Since different quadrants in Calgary are served by different acute care hospitals and different Home Care teams, the researcher interviewed consumers from all of the geographical Home Care areas in the CRHA. Consumers in the study were referred from all of the full service hospitals in the CRHA: Foothills, Rockyview, Peter Lougheed and the Bow Valley Centre. (Interviews were completed before the Bow Valley Centre closed in the spring of 1997.) The interviews were conducted between November 1995 and December 1996.

FIGURE 4
HOME CARE TEAM BOUNDARIES
CITY OF CALGARY



Heavy black lines are Calgary Health Services/Home Care team boundaries.

Team 6 is the Hospital Liasions and Intake Coordinators.

Black circles are Calgary Health Services District Offices for Prevention and Promotion, Nutrition, Dental, and Speech-Language Pathology.

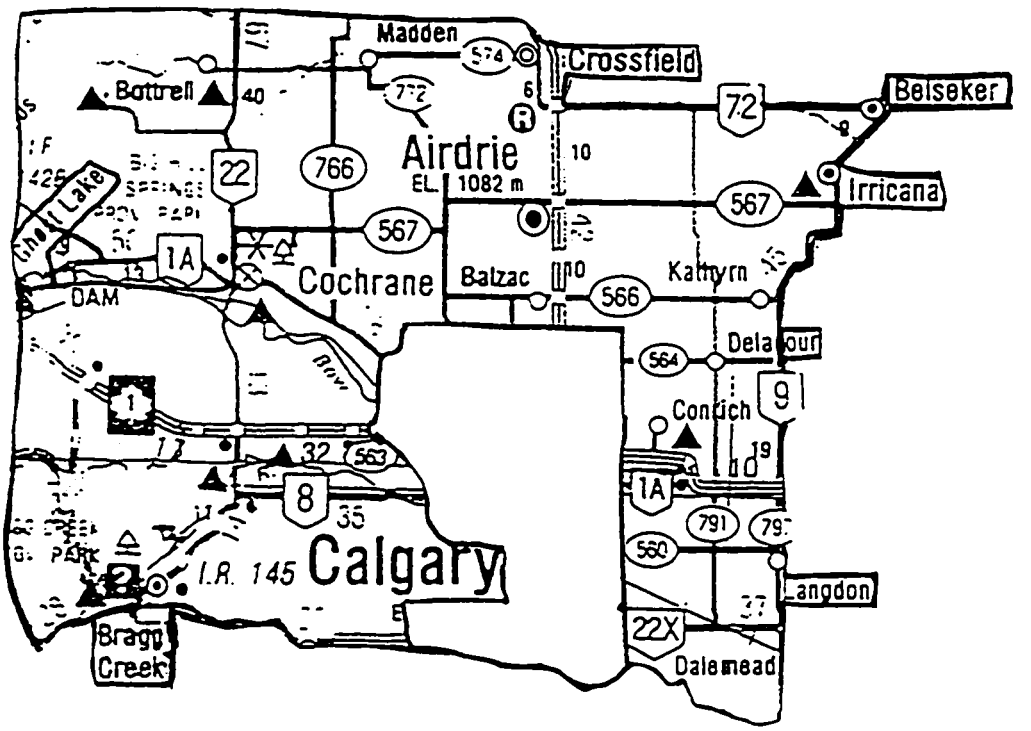
Between November 1995 and November 1996 each of the six Home Care areas was randomly selected to be the study area for one week. During that week, in the selected Home Care area, a letter was sent from Home Care (see Appendix I. A.2. Initial Letter to Consumer) to all consumers referred for short-term Home Care from an acute care hospital. The letter explained the study. If consumers did not wish to be part of the study they were asked to call a contact person in Home Care whose name and phone number were included in the letter. The exception was the rural area served by Team 7 (see Figure 5) which had fewer consumers referred for Home Care than did the other areas in the city of Calgary. Therefore letters were sent to all consumers from this area who were discharged from an acute care hospital during a one month period, rather than a one week period.

The Home Care Information System (HCIS) generated a list from the designated team in the designated area during the one week time period (one month time period for Team 7). The HCIS list included all consumers who had been discharged from an acute care hospital who were registered for short-term Home Care services. The HCIS list was compared with a list kept by the team secretary of the letters that were sent out. This allowed the researcher to compare the consumers in the study with the total group of consumers in the Home Care area who were eligible for the study.

FIGURE 5
HOME CARE TEAM 7 BOUNDARY

Team 7 staff cover the rural parts of region 4.

The approximate boundaries of the area served by team 7 are indicated on the map below.



The researcher waited until participants had been home from hospital for at least one week before contacting them by telephone. This delay was to allow time for the consumer a) to get settled at home, b) to start Home Care services, c) to receive the initial letter, and d) advise Home Care if they did not wish to participate. Most consumers were interviewed within one month of their discharge from hospital. All consumers were interviewed within two months of discharge. If consumers did not call and ask to be excluded from the study, the researcher telephoned them and asked if they would be willing to be interviewed (See Appendix I. A. 3. Guide for Telephone Call to Consumer).

If the consumer agreed to the interview, the researcher asked which location the consumer would prefer for the interview. One consumer was interviewed in a private room in the public library in his community. All other consumers were interviewed in their homes. A thank you letter was sent to all consumers interviewed in person (see Appendix I. A. 4. Thank You Letter).

Subjects who did not wish to be interviewed in person were interviewed by telephone. Most personal interviews lasted somewhat longer than an hour (60 to 90 minutes); the telephone interviews were much shorter (5 to 10 minutes). With the permission of the interviewee, all personal interviews were recorded and later transcribed. The transcript of the interview was crucial for the data analysis process.

B. INTERVIEW STRATEGY

Data were obtained primarily through in-depth personal interviews which Marshall and Rossman (1989) describe as "a conversation with a purpose". McCracken (1988) views an interview guide, which he terms a "questionnaire", as indispensable for a long, qualitative interview. In this study, an interview guide was used to initiate discussion in several key areas (see Appendix I. A. 5. Interview Guide). This did not preempt the open-ended nature of the interview, and within each of the questions there was still the opportunity for "exploratory unstructured responses" (McCracken, 1988).

In addition to gathering administrative and demographic data about consumers (see the last page of the interview guide), there were five types of questions related to coordination and transition experiences:

1. Open unstructured questions asking about the person's experience leaving hospital. (Question 1)
2. Structured prompts to elicit information about categories that began to emerge as important in the transition experience. (Questions 2-F,G, H.)
3. Open questions asking about the meaning of coordination to the consumer and their experience related to coordination. (Questions 3-A,B,C, F.)
4. Structured prompts about gaps or duplications in services to elicit more information that might be related to coordination. (Questions 3 - D,E.)

5. Specific questions about three categories that Alter and Hage (1993) suggested are related to coordination--access, comprehensiveness, and compatibility. These (Questions 4-B to D) were developed by the researcher for this study. Text of the actual questions is included in Chapter 4 - Findings.

During the course of the interview, the researcher also asked questions to verify that the researcher understood what the consumer was saying.

C. DATA COLLECTION

The unstructured questions about coordination and the specific questions about the literature remained the same throughout the study. However, the questions about the transition experience evolved during the course of the study, as is often the case in qualitative research (Creswell, 1994). For example, as categories began to emerge from the initial interviews, subsequent participants were asked about these categories. As discussed above, there were a number of changes in the organizational structure of the Calgary Regional Health Authority during the course of the study (see 'Setting', for details). Consumers did not spontaneously comment on any of these changes during the course of the interviews. During the last three personal interviews, consumers were explicitly asked if they were aware of any changes related to health care and if they thought that there had been any changes that affected their own health care in the six months before their interview. (Question 2-K)

With the permission of the consumer, all the interviews were taped and later transcribed for analysis. In addition, during the course of the interview, the researcher made notes on a blank copy of the questionnaire. The same day, or the next day, when the researcher prepared the thank you letter for the participant, the researcher added memos to the file about the interview. The notes and memos from the interviews were included in the data analysis process

V. DATA ANALYSIS

The constant comparison method, which is a central feature of grounded theory (Glaser & Strauss, 1967), was used to analyze the interviews. This process began with reviewing the transcripts of the interviews. Portions of the interview were identified with a particular word or phrase that captured the concept in the text. This word or phrase is called a "code" and the process of reviewing the interviews and deciding on an appropriate term for sections of text is called "coding". Some codes were words or phrases taken directly from the interview, while others were chosen by the researcher to represent the idea or concept in the text. Nud*ist software was used to record the codes and the sections of text from the interviews associated with each code, as well as to retrieve sections of coded text for further analysis.

Glaser and Strass (1967) identify four steps in the constant comparison method.

These are outlined below with a description of how this process was used in the present study.

1. Comparing incidents applicable to each category

The first interview was coded into as many categories as possible. As the coding continued, each new section of text was compared with previous sections and either added to an existing category or a new category created.

2. Integrating categories and their properties

As the coding was taking place, the researcher wrote notes (memos) about the categories and the sub-categories (properties) that were becoming evident in the data. The categories and sub-categories as well as the relationships in the data, were constantly reviewed with ongoing revisions of the codes.

3. Delimiting the theory

The theory began to develop as the relationships among the various categories and subcategories emerged. As Strauss & Corbin (1990) observe, data collection, analysis, and theory stand in a reciprocal arrangement with each other with simultaneous collection, coding, and analysis of data. Themes became evident with the initial interviews, that were then explored during subsequent interviews.

Glaser and Strauss (1967) suggest that as theory develops, the theory and the categories are delimited by the constant comparative method and theoretical saturation (i.e., no new data are emerging about the categories with continued data gathering). In the present study, data collection continued until all the geographical areas in Calgary had been studied to enhance the completeness of the sample in the study. Theoretical saturation was achieved in many categories before the interviewing was complete.

4. Writing Theory

As the process continued, the coded data and notes about the relationships in the data formed an analytic framework that was the basis of the substantive theory. Glaser and Strauss (1967) advise that the theory should be an accurate statement of the matters studied and in a form that others can use. The first point, related to the accuracy of the findings, is reviewed in the "Discussion Chapter" (Chapter 5) in the section entitled "Maintaining Research Quality" (Chapter 5 - Section VII. A). The second point, related to theory, is also addressed in the "Discussion" Chapter. The theory is presented in the "Discussion" in two forms: as text which explores the relationships in the findings (Chapter 5 Section II.) and as a diagram, (Chapter 5 Section III.) which provides a visual model and propositions about the relationships in the findings.

Nud*ist (Non-numerical Unstructured Data Indexing Searching and Theorizing) software was used as a convenient way of managing the data. The program made it easy to mark passages in the interviews and assign codes. Richards and Richards (1994) who developed the program describe this as the "code and retrieve method" since coding sections of text allows the retrieval of information from different interviews that deal with the same topic.

The hierarchical levels in Nud*ist do not use the Glaser and Strauss (1967) terminology of categories and properties. Rather the codes are grouped into an index system by the researcher (see Appendix II. B.) and each position in the index system is called a node. The index system with a large number of nodes can be displayed as a list of major headings (categories) with as many sub-headings (properties) as the researcher wants to add. This index system can also be displayed visually as a tree with various branches.

The index system was continually refined by examining the segments of text at each node and considering how the various nodes related to each other. The index system is an integral part of the data analysis process. It is continually refined and enriched as new sections of text are examined and added to existing nodes, or new nodes are created. Thus the generation of the index system is in fact an important contribution to developing theory (Richards et al., 1994).

As the theory develops, there is a continuous cycle of reviewing the sections of the interviews at the nodes to see if the codes are still appropriate, summarizing the text at each node, and revising the index system so there is congruence between the nodes. The index system is a guide to the emerging theory, since it helps to document the relationships that are becoming apparent. In writing up the findings, quotations were used from the interviews to document why particular codes were chosen, as well as to support the emerging theory.

VI. REVIEW BY PARTICIPANTS

As part of the process of maintaining the quality of the research (See Discussion Chapter 5. Section VII.), a one-page summary of the findings about the consumer's view of coordination was developed and sent to a sample of consumers for their review.

The summary and a covering letter were evaluated by two boys in Grade 9 and one girl in Grade 7 to ensure that the material was clearly expressed. The summary was revised slightly to reflect their comments (see Appendix II. C. Summary and Letter).

The summary and letter were sent to a sample of consumers who had been interviewed in person. Two consumers from each of the geographical Home Care

areas were selected based on a) the usefulness of the original interview and b) obtaining a sample that represented the group that had been interviewed (based on age and sex). Of the 12 summaries that were sent out, eight consumers were interviewed by telephone by the researcher. The group of consumers who were interviewed included at least one consumer from each of the six geographically defined Home Care areas. Three consumers could not be contacted and one consumer declined to be interviewed again because his wife had recently died. Each subject was asked about each section in the summary. These follow-up telephone interviews lasted about 15 minutes.

VII. ETHICAL CONSIDERATIONS

A. CONSENT

The consumer had four opportunities to decline to participate in the study and three opportunities to give active informed consent.

1. In the initial letter about the study sent from Home Care, consumers were advised that if they did not wish to be telephoned by the researcher, they should call Home Care.
2. The researcher contacted consumers by telephone. The study was explained and consumers were asked if they were interested in participating. If consumers agreed to a personal interview, an appointment was made at a time and

location that was convenient for the consumer. If consumers did not wish to be interviewed in person, consumers were asked if they would be willing to answer a few questions about coordination over the telephone. Consumers were advised if they chose not to participate in the study, it would not affect their Home Care or access to any other health services.

3. At the time of the interview, the researcher explained the study again and asked if the consumer was still willing to proceed with the interview.
4. The researcher reviewed the consent form (see Appendix II.D. Consent Form) with the consumer, asked the consumer to sign the form, and left a copy of the form with the consumer.

B. CONFIDENTIALITY

The researcher conducted all interviews personally. For transcription, each interview was identified only by number. The quotations used to illustrate themes or ideas were identified by number and included only the gender and age of the consumer.

C. REVIEW

The proposal was reviewed and approved by the Research and Development Committee at Calgary Health Services and The Conjoint Medical Ethics Review Board at The University of Calgary.

CHAPTER 4: FINDINGS

I. OVERVIEW OF THE CHAPTER

The opening section of this chapter describes the participants in the study. The next section (Section III) entitled "The Consumer's Views About Coordination", contains the responses to an unstructured question asking about coordination. Consumers were then asked more structured questions about their transition experience between hospital and home. Coordination emerged as an important aspect of the transition. This information is captured in the subsection entitled "Coordination and the Transition Experience" (Section III.E.). The majority of the responses to the structured questions about the transition experience are contained in Section IV "The Transition From Hospital to Home".

Section V, "Health Care Services" describes gaps, duplications and general comments about health care services from consumers. The final section (Section VI.) presents consumers' responses to three categories that the health services literature (Alter and Hage, 1993) identifies as important to the coordination of services--access, comprehensiveness and compatibility.

II. PARTICIPANTS

A. DESCRIPTION

As described in Section IV. A. (Recruitment) in Chapter 3, participants were recruited from all the geographic Home Care areas served by the CRHA. No attempt was made to select participants to obtain a representative sample of short-term Home Care consumers. After the study was completed, the demographic and diagnostic characteristics of the consumers who were interviewed were compared with consumers who were eligible for the study to determine if the consumers who were interviewed reflected the group who were eligible. In addition, detail about the participants in this study was provided to allow other researchers to be able to determine how relevant the findings from this study might be to their own research.

There were 64 potential participants in the study. These were consumers who had been in hospital and were subsequently referred for short-term Home Care services and lived in the randomly selected Home Care area (see Data Collection in Chapter 3). Of the 64 potential participants, 10 consumers declined to be interviewed and 21 were not eligible for the study for the following reasons: an initial contact letter from Home Care was not sent to them (7); they could not be reached by telephone to set up an interview (4); they could not be interviewed because of poor health (2), psychiatric problems (2), or limited English speaking ability (4); or because they did not actually receive any Home Care services (2). Thirty-three consumers took part

in the study. Twenty six consumers were interviewed in person and seven were interviewed by telephone.

B. CONSUMER CHARACTERISTICS

The sex, age, diagnosis and geographical location of the consumers in the study is presented in the following section.

1. Sex

Slightly more than half of the consumers in the study were female (see Table 1).

TABLE 1
SEX OF CONSUMERS IN THE STUDY

CATEGORY	NUMBER	SEX
INTERVIEWED	33	F=17 (52%) M=16 (48%)
NOT INTERVIEWED	31	F=21 (68%) M=10 (32%)
TOTAL	64	F=38 (59%) M= 26 (41%)

2. Age

The largest number of consumers were in the 60 to 79 years of age category. Generally, the age distribution was similar for consumers who were interviewed and those in the total group eligible for the study (see Table 2). The exception was the youngest age category (20-39) in which there was a higher proportion of consumers in the group that was interviewed compared with consumers who were not interviewed.

TABLE 2
AGE DISTRIBUTION OF CONSUMERS IN THE STUDY

	AGE CATEGORIES IN YEARS				
	20-39	40-59	60-79	80+ yrs	total
INTERVIEWED	8 (24%)	5 (15%)	13 (40%)	7 (21%)	33 (100%)
NOT INTERVIEWED	3(10%)	4 (13%)	17 (55%)	7 (22%)	31 (100%)
TOTAL	11 (17%)	9 (14%)	30 (47%)	14 (22%)	64 (100%)

3. Diagnostic Groups

There was a total of 11 major diagnostic groupings (categories of illness or injury) represented by consumers in the study. However, four diagnostic categories accounted for about 70% of the consumers in the study (see Table 3). The distribution of consumers in these four major diagnostic groups (Musculoskeletal, Circulatory, Digestive, and Injury) was similar for consumers who were interviewed as for those not interviewed. The major difference between the groups is that four consumers who were not interviewed had a diagnostic code indicating a nervous system or mental disorder, whereas no consumers who were interviewed had this diagnosis.

TABLE 3
DIAGNOSTIC CATEGORIES OF CONSUMERS

DIAGNOSIS	Interviewed	Not Interviewed	TOTAL IN STUDY
Musculoskeletal System	9(27%)	8(25%)	17(27%)
Circulatory (Cardio & Cerebrovascular)	7(22%)	6(19%)	13(20%)
Digestive System	4(12%)	3(10%)	7(11%)
Injury (includes surgery) & Poisoning	4 (12%)	3(10%)	7(11%)
Nervous system, Mental disorders, Dementia	0	4(13%)	4(6%)
Other	9 (27%)	7 (23%)	16 (25%)
TOTALS	33	31	64

4. Geographical Location

The demographic characteristics of the consumers living in the six geographic Home Care areas (see Figures 4 and 5 in Chapter 3) were similar in many respects (see Table 4). For most geographical areas there were more women than men in the study; the exception was Area 7, the rural area served by the CRHA, in which there were more men. The mean age and age range were similar in all areas. The youngest mean age was in Area 4, the South West, and oldest mean age was in Area 5, the central area of the city.

TABLE 4
GEOGRAPHICAL LOCATION OF CONSUMERS

HOME CARE AREA	INTERVIEWED	MEAN AGE (Age Range) Years	SEX
Area 1 (NW)	6/11	64 (23 - 82)	F=7 M=4
Area 2 (NE)	5/16	60 (21 - 89)	F=10 M=6
Area 3 (S/SE)	6/12	66 (39 - 86)	F=8 M=4
Area 4 (SW)	6/9	58 (29 - 82)	F=6 M=3
Area 5 (Centre)	5/8	72 (53 - 82)	F=4 M=4
Area 7 (Rural)	5/8	67 (38 - 86)	F=3 M=5
TOTAL	33/64	65 (21 - 89)	F=38 M=26

The most distinctive area was the North East quadrant of Calgary (Home Care Area 2). All three non-Caucasian consumers who were interviewed resided in this area. Area 2 had the largest number of potential consumers (16), but it also had the largest number of consumers who were not interviewed (11/16). Some consumers in Area 2 could not be interviewed because their English language skills were not strong enough (2/11). There were 2/11 consumers in Area 2 who were not eligible for the study because they did not actually receive any Home

Care services other than an initial assessment. There were no other areas in the CRHA in which consumers were not eligible for the study because they did not actually receive Home Care Services.

C. TELEPHONE VERSUS PERSONAL INTERVIEWS

Seven consumers did not want to be interviewed in person but consented to a short telephone interview. The telephone interviews with consumers were much shorter than those conducted in person (5 to 10 minutes versus 60 to 90 minutes). The group of seven interviewed by telephone had more women (6) than men (1), and relatively more consumers (3/7) in the oldest age group (80 years or more), compared with those who granted a personal interview (4/26). Those interviewed by telephone received fewer Home Care services. The majority had three or fewer Home Care visits with a duration of a week or less. In contrast, most of the consumers who were interviewed in person were still receiving Home Care services at the time of their interview (3 to 4 weeks after discharge from the hospital).

The findings contain data from both personal and telephone interviews. However, since the interviews conducted in person were much longer and more comprehensive, the findings are more reflective of consumers interviewed in person and quotations from the personal interviews are used more often. There

was no evidence during the course of the telephone interviews of findings which contradicted those obtained from personal interviews.

D. HOME CARE SERVICES

The majority of consumers who received care at home received nursing care (20/33). The type of nursing care was varied for example, checking vital signs or changing wound dressings. Nursing support for a Home I.V. was the largest single type of nursing service provided (9/20). Of consumers who received therapy (Physiotherapy, Occupational Therapy or Respiratory Therapy) at home (6/33), the majority had received surgery on their legs in the hospital. A few consumers (3/33) had a combination of personal care (help with bathing etc.) and nursing care and/or therapy. There were no consumers interviewed by telephone who had a combination of services.

E. CONSUMERS INTERVIEWED IN PERSON

1. Ethnic Background

The overwhelming majority of consumers who were personally interviewed were Caucasians from Canada (20 of 26). There were three other Caucasians, two from Europe and one from the United States. There was one person from each of three other ethnic backgrounds--Africa, Pakistan, and Lebanon.

2. Living Arrangements

The living arrangements for the 26 consumers who were personally interviewed were fairly evenly divided; 9 lived with their families, 7 lived with their spouses, and 9 lived alone. One person lived in a lodge. The 2 consumers who lived with their children owned the family home that everyone was living in. There was about the same number of men and women either living with a spouse (4 with wives, 3 with husbands) as were living alone (5 men and 4 women).

3. Employment Status

Half of the consumers were retired (N=13, Mean Age 74 years). In the middle age group, an equal number of consumers were on temporary leave from the work force (N=4, Mean Age 57 years) or on social assistance (N=4, Mean Age 45 years). There were also two homemakers. In the youngest age group (N=3, Mean Age 22 years), all consumers were students.

F. SUMMARY

In summary, the demographic characteristics (age, sex, and diagnosis) of consumers who were interviewed for the study were similar to those of all consumers who were referred for short-term Home Care services from an acute

care hospital during the study. The only major difference observed was that there were four consumers with a diagnostic code indicating a mental or nervous system disorder in the group of consumers who were not interviewed.

The majority of consumers who were interviewed in person were Caucasian, two thirds lived with a family member (one third lived alone), and half of the group was retired.

III. THE CONSUMER'S VIEW OF COORDINATION

A. OVERVIEW OF THE SECTION

This section begins by introducing individual words or terms that consumers identified as synonymous with, or related to, coordination. Next, multi-faceted ideas that consistently emerged from the interviews as important components of coordination are examined. These components include: people, information, communication, and consumer focus. The role of the consumer, which emerged as a central concept, is developed in more depth, including a description of the actions of consumers that are related to coordination. Aspects of the heath care system identified as important to coordination are described. Finally, coordination and the transition experience are discussed.

B. DESCRIPTIONS OF COORDINATION

1. Coordination Terms

When asked "What does coordination mean to you?", consumers had a number of responses. Words or phrases from individual consumers to describe coordination included: *"cooperation"*, *"working together"*, *"putting things together"*, *"connection"*, *"timeliness"*, *"continuity"*, and *"team work"*.

Since the context for the study had been established as their experience leaving hospital and coming home, many consumers answered the general question about

coordination by describing it in relation to health care. Consumers were also asked "Is there anything different about coordination in health care compared with coordination generally?" For most consumers there was no difference, but some indicated that coordination in health care was related to health care providers.

> *Well, it just involves, you know, specific groups of people, doctors and nurses and physios.*

2. Components of Coordination

The following components related to coordination emerged a number of times from different consumers and have more than one aspect.

Component--People

People were identified as an important part of coordination.

> *She's an excellent nurse. She's been very good to us, you know. She really looks after us when something goes wrong.*

A number of consumers specifically mentioned their doctors when asked to define coordination.

> *I think I have to be followed by the same doctor.*

The role of specialists versus the family doctor seemed to vary somewhat between consumers. In one case it was close communication between two specialists that the patient equated with coordination. In other cases, the family doctor had a prominent role in coordinating care.

> *Once I was discharged, they turn you over to your family doctor, and in this case, who works out of the* ---(name of Hospital) *as well. He followed it all the way through. In fact I was admitted through his efforts.*

Component--Information

There were two aspects to information related to coordination: 1) an expectation that there would be staff members at all sites in the system who were informed about procedures or services that consumers needed; and 2) staff members should have information about the individual consumer.

An illustration of the first aspect of the information component is a patient who had a midline IV inserted to allow her to receive intravenous antibiotics at home. She had problems with the IV. When she went to the emergency room of the hospital to which she had been told to go, staff there did not seem to know how to handle the problem and eventually just removed the midline IV.

> *The basic* [problem] *was just the fact that people weren't knowledgeable in the actual home I.V. program. If they're going to go ahead with the program, maybe they should make sure there's people that are trained.*

The consumer expected that if a procedure is offered (i.e., Home I.V.) that the system would make provision for informed staff to be available at major system-access sites (such as emergency rooms) to support this procedure. Another consumer who experienced problems with her home IV had a similar experience at the same hospital.

> *They just put a temporary in, because on Sunday, there's nobody there.*

These experiences are also discussed under the heading "Gaps in Health Services" (V.B.1) in "Health Care Services" (Section V.) in this Chapter

The other aspect of "information" was knowledge about the individual consumer. One consumer had a severely injured arm as a result of a car accident in another province. He observed

> *I could tell the difference in the hospital nurses, in the OT and physiotherapy people, as to whether or not they had actually bothered to read my chart or seen my X-rays.*
> ...
> *As I say it's one thing to say "You've got a broken arm". There's another thing to see my X-rays with all the little wee bone chunks and 20 screws and 2 metal plates within 4-1/2 inches, for you to say "You've got a broken arm"*
> ....
> *The key point here being that my left arm was shattered, not broken, shattered.*

He had two solutions: one was to have a brief summary at the top of the chart, and the other was to have a picture of the X-Ray at the front of the chart so staff would know the extent of the injuries they were dealing with.

Another consumer was anxious that his health care providers in Calgary be informed about his medical condition because he had been hospitalized in the United States.

> *My concerns weren't the records transfers*--[it was] *that they'd be picked up and actually looked at.*

He reported that the records were transferred and his new health care team in Calgary did read them and were well prepared to care for him.

Component--Communication

The most consistent component identified as related to coordination was communication. This was defined by one consumer as:

> *Communication, knowing what the plan is and following it through.*

There were two aspects to communication that emerged as important to coordination: communication between health care providers and communication between providers and the consumer.

1) Communication Between Health Care Providers

The following two examples illustrate the consumers' views about effective communication between health care providers.

CONSUMER 13 (Male, Age 86)

> INTERVIEWER: *That sounds like there's a good relationship between your family doctor and the doctors at the hospital?*
> CONSUMER: *That's right. They are closely related. One knows immediately if I go and see my Doctor here, Dr. H.,--Dr. C. gets all the dope on it. The communication is fantastic.*

CONSUMER 22 (Male, Age 51)

> INTERVIEWER: *Were there other examples of communication?*
> CONSUMER: *The Home Care nurses always knew. They marked everything on the chart in the home so if one nurse came in--there was a different nurse for the weekends than there was through the weekdays--so everything was on the chart. She knew everything she needed to know.*

Next is an example of what happened when communication between health care providers broke down.

CONSUMER 4 (Female, Age 35)

It turned out to be a big fiasco. I had Home Care nurses say, "Oh, they shouldn't have done that. They shouldn't have taken it out. They should have checked with us first". Well, I didn't know what to do. So I was kind of hands up in the air thinking, "I don't know". But it wasn't really anything I did. It was just a lack of communication, lack of people knowing what to do and stuff.

2) Communication with the consumer

The other aspect of communication related to coordination was communication between the health care providers and the consumer. The following are examples of responses to the question "What things are important for coordinating care between the hospital and Home Care?"

CONSUMER 22 (Male, Age 51)

I think just the communication between them was excellent. Like I said, they were there. I hadn't been home but a short time when the first call came and they wanted to know, "Do I need to see you today". If not, we'll start tomorrow morning. The communication was the big thing.

CONSUMER 29 (Male, Age 59)

At the time of discharge when the surgeon comes to see you and all the instructions are being given--what is to be done, what is not to be done, what was done during your surgery and all these things.

Component--Consumer Focus

There were three aspects to Consumer Focus as a component of coordination: 1) involving consumers; 2) holistic care; and 3) recognizing individual needs.

1) Involving consumers in decisions and discussions about their own care.

CONSUMER 28 (Male, Age 21)

INTERVIEWER: *Now, any pointers or any comments about what kinds of things that you think are important about coordination for people who are in hospital and coming home?*

CONSUMER: *I think if they do everything the same way as they did to me, that seemed like, it was more than I expected. They involved me more and I knew more about everything than I expected to. As long as, if that's the procedure they follow all the time, I think that's about as much as they can do.*

2) Holistic approach to the consumer

In the following excerpt, a young blind woman found that the health care providers did not understand the barriers that her blindness created for her. For example, she was given a walker which required the use of two hands but she needed her hands free to help guide herself around her apartment.

CONSUMER 2 (Female, 23)

INTERVIEWER: *Now is there anything that you would like to add just about coordination generally, in terms of what kinds of things are important to make sure that what happens in hospital is in fact coordinated with care at home?*

CONSUMER: *Well, the only thing I can think of is, that when whoever is coordinating, is coordinating, I think they need to take into consideration the person as a whole not just whatever it was that brought them in and out of hospital. I really think that's sad that they've forgotten that we're people. I guess that's in the whole thing. We're not just studies or patients. So I'd like to see a more holistic approach.*

3) Recognising Individual Needs

For the consumer in the next excerpt, her transition between hospital and home went well because Home Care had *"recognised her special needs"*. In hospital, however, she felt the staff did not understand her individual health needs. After surgery on her

hip, she had been transferred from the orthopaedic ward in one hospital to a general surgery ward in another hospital. Her suggested solution was greater involvement of her family doctor in her hospital care.

CONSUMER 34 (Female, Age 66 years)

> *There were set timetables for this, or for that, or for the other thing but nobody was paying attention to ME that I might not fit into their timetables.*
>
> *And so those were things that I felt the family doctor would have been really able to handle because she has known me for a certain length of time and knows exactly what kind of a person I am health-wise.*

C. CONSUMER ROLES

Closely related to a consumer focus is the role that consumers play in coordination. A very significant finding is the importance of consumers in coordinating their own care. This came up in more than half (17) of the 26 interviews. It was a factor for men and women and for all age groups.

Consumer involvement may include a variety of actions that have been classified as: communicate, monitor, manage, inform self, and direct.

1. Communicate

In the following example, the Home Care nurses would call the patient to ask how often her doctor wanted her dressings changed. The nurses would then alter the schedule of home visits accordingly.

CONSUMER 14 (Female, Age 50)

INTERVIEWER: *Do the* [Home Care] *nurses call the doctor's office or does the doctor call the nurses?*
CONSUMER: *I think he gets hold of them but it's usually done through me first.*
INTERVIEWER: *So he tells you what the changes are?*
CONSUMER: *Yes. When he changed it* [the number times the dressing should be changed] *from twice a day to once a day, the nurse that initially came, the one that usually comes in, phoned me that afternoon after I'd been to the Doctor and asked me what--*
INTERVIEWER: *She called you to say, "What happened?"*
CONSUMER: *What, you know, he said. She changed it* [her home visits] *down to once a day.*
INTERVIEWER: *Okay, so the nurse basically did it through you?*
CONSUMER: *Yes. Through me.*

CONSUMER 35 (Male, Age 68)

I phoned her [his previous Home Care nurse] *when I got the news that they were finally going to do it.* [Operate on his hip]. *I phoned her and she said okay, you mention it to the nurse* [in the hospital] *when you're released for them to get a hold of us* [Home Care] *and say you're going home.*

2. Monitor

Other consumers indicated it was up to them to carry through with their therapy and keep track of how they were doing.

CONSUMER 15 (Female, Age 82)

She checked my exercises. She hasn't had a chance to do much. I'm just carrying on with the exercises the nurse in the hospital gave me. And I keep a chart for myself to see if I'm going up or going down or what I'm doing.

The monitoring role was also evident for another consumer who wanted to avoid problems. She had a midline IV inserted while in hospital and it was very clear to her that the hospital staff had no experience with this.

CONSUMER 4 (Female, Age 35)

> *There were no nurses on my floor that knew anything about a midline at all. In fact when they put it in, I had several nurses come in to watch them put it in because they had never seen it and were interested in seeing how it was done. It was like the talk of the floor because nobody really had seen it before.*

When the hospital nurses wanted to start using the midline I.V. the consumer took an active role in this decision.

> *Well, actually there was a point where the regular I.V. had come out and the nurses* [in the hospital] *wanted to start using the midline--because I hadn't started using it, they* [Home Care] *had just inserted it--and I didn't want them to touch it because I was afraid they would do something. So I had them phone the Home Care nurse and see how to do it first. A couple of the nurses weren't very happy with me but at that point I thought-- "It took them forever to put the midline in, leave me alone". That was a little tense.*

3. Manage

The management role of the consumer was evident with a consumer who was very involved in adapting his environment both in the hospital and at home, to allow him to manage with severe injuries to one side of his body.

CONSUMER 5 (Male, Age 39)

> CONSUMER: *I had to call my brother to bring in proper duct tape and make one* [modifications to his walker] *in the hospital. That same walker is still in the hospital on reserve for me whenever I go in there for physio.*
>
> ...
>
> CONSUMER: *The occupational therapist introduced me to various things that should help around the house. None of them worked. For example, she was trying to get me to use what's known as a tub seat and a bar bolted to your tub to allow you to get into the tub. I told her that it just wouldn't work but she tried to get me using it. What would be involved was that I would have to use my left arm to support myself to do the mechanics in the bathroom. My left arm is the one that is damaged* [shattered in a car accident] *that I can't give my support to.*

INTERVIEWER: *Have they been able to offer any suggestions or equipment that you might use, or ideas about how to fix it up?*
CONSUMER: *I've basically kind of fixed up most of it myself.*
...
CONSUMER: *Yeah, I think what it comes down to is who's the coordinator? The coordinator seems to be me, the customer.*

4. Inform Self

Consumers would seek information from their own sources about what to expect before going into hospital or coming home.

CONSUMER 9 (Female, Age 79)
I did quite a bit myself before I went into hospital. I phoned people that had been in the____Hospital or had been in surgery and I asked them what I was supposed to take. --And another thing is that I asked them everything that I could about what, like after care or things like that. And they told me.

5. Direct

The extreme example of consumer involvement was an ex-Navy man who was very definite that to make things happen in the health care system, either in hospital or at home or in the transition between the two, people had to take charge themselves.

CONSUMER 8 (Male, Age 76)
INTERVIEWER: *What would you tell your buddy about the experience of being in hospital and coming home?*
CONSUMER: *Don't leave it to them. Take your situation in your own hands. You have to take your situation in your own hands.*

D. COORDINATION AND THE HEALTH CARE SYSTEM

In analyzing the data related to the definitions and meaning of coordination to consumers, a number of specific health care system activities were identified by consumers as important to coordination. These included: a) a visit by the Home Care coordinator while the consumer was in hospital; b) regular phone calls by Home Care personnel to the consumer and a phone number consumers could call if they had problems; c) health care staff having the time and training to provide services that consumers felt they needed; d) providing written instructions; and f) keeping the chart in the consumer's home.

A second aspect of system/consumer interaction was utilization of the system by the consumer. There were very disparate approaches to utilization of the system by different consumers. For example, one consumer refused to leave the hospital until he felt ready, although there were other sick people waiting, because, in his view, "*I was pretty sick myself*". His very strong role in his care resulted in increased utilization of the hospital since his discharge was delayed for about three days. When he was discharged, the transition to his home went very smoothly because in his view he was "*ready*". One could speculate that the short delay in his discharge may have prevented the use of more intensive Home Care services or even possible readmission, since both he and his wife were very definite in stating that she could not have managed his medical problems at home had he been discharged earlier.

In contrast, another consumer volunteered to learn how to change his own dressing at home so the Home Care nurse would not have to come to see him as often, thus freeing her time to provide care for *"someone who needed her services more"*.

E. COORDINATION AND THE TRANSITION EXPERIENCE

The information in the preceding section came from consumers' responses to open-ended questions about what coordination meant to them. This section reports responses to more directed questions about consumers' own transition experiences from hospital to home. As part of the discussion of the transition experience, consumers were asked if their hospital care and Home Care had been coordinated. Their responses to that question provided validation for the information that emerged in the previous section about coordination, and also extended the concept of coordination beyond the ideas that emerged in the previous section.

1. Evaluating Coordination

Consumers were asked if the care they received at home was coordinated with their care in hospital. The majority of consumers indicated their care had been coordinated.

CONSUMER 14 (Female, Age 50)

> *Oh, like I say, for me everything was coordinated. I mean I honestly did not expect the nurse to come in the evening the day of discharge. And she phoned me first to make sure what time was convenient.*

CONSUMER 16 (Female, Age 82)

CONSUMER: *They went so far at the hospital and then they gave me exercise charts and different things there to carry on here, and then I worked with the therapist at home. It was a very smooth transition.*

INTERVIEWER: *Is there anything else you would like to add about the coordination between hospital and home?*

CONSUMER: *No, nothing particularly except it was extremely good.*

When asked to describe the transition from hospital to home, consumers often used examples related to their own personal definition of coordination to highlight why, in their view, services were coordinated. This provided internal validation for the definitions of coordination that were elicited previously. For example:

CONSUMER 29(Male, Age 59)

As I said, the coordination, teamwork, in hospital was excellent, even the first day when I was transferred from hospital '1' to hospital '2'.

[Previous Coordination Description was Teamwork]

CONSUMER 35(Male, Age 68)

INTERVIEWER: *Now, did you feel there was coordination between the kind of care that you had in hospital and your Home Care?*

CONSUMER: *I think so, yes."* [Discussion about his experience]...*The communication was there.*

[Previous Coordination Description was Communication]

2. Expanding the Concept of Coordination

In discussing their transition experience, as well as reaffirming their initial definitions and descriptions of coordination, consumers also expanded upon the concept of coordination. The concept of service providers crossing sectors was not mentioned when consumers were asked to define coordination, but it emerged in their comments

explaining why they felt their care was coordinated. An example given by a consumer to illustrate that coordination was present in the transition experience was a description of providers' from one sector (Home Care) going to another sector (the hospital) to see the consumer.

CONSUMER 22 (Male, Age 51)

> *The coordination started with the Home Care people at the hospital coming to my room, showing me how to use the pump, how it was going to be handled, what they were going to do and then giving me all the information on the Home Care people who would be coming.*

In the next example, in addition to going to the hospital, the Home Care nurse also obtained help from hospital personnel to assist with the procedure.

CONSUMER 28 (Male, Age 21)

> INTERVIEWER: *Did you feel there was coordination between the hospital and Home Care?*
> CONSUMER: *Yes. Even just from getting the I.V. line put in, the Home Care nurse came* [to the hospital] *and then she also asked for the assistance of one of the nurses at the hospital because when they did this there was a real sterility concern because this thing was going in me and they didn't want anything --*
> CONSUMER: *Actually she* [the Home Care nurse] *put it in and then the nurse at the hospital just assisted her with all the -- like, she would do the alcohol, like cleaning my arm at the spot where it was going to be and everything. Even there, both the Home Care nurse and the hospital nurse were working together.*

Another activity that signalled coordination for the same consumer was the nurse from one sector (Home Care) facilitating access for the consumer to services in another sector.

My foot was still quite swollen, especially in the toe area. It hadn't gone down a whole bunch yet and they were concerned that maybe the specialist, Dr. L., would want to keep the I.V. in longer. She [the Home Care nurse] *phoned Dr. L. up and made an appointment for me to go in to see him.*

In evaluating whether services were coordinated, some consumers went beyond just commenting on Home Care and the hospital, and considered their health care in the context of their environment.

CONSUMER 6 (Female, Age 82)

It's extremely important to know what health care are doing. It's very important. And to see to it that they are coordinating with the management [of the senior's lodge] *and the doctor and the residents* [of the lodge], *and I feel they are.*

3. Negative Experiences

There were a few consumers who experienced negative aspects in their care or in the transition between hospital and home. For these consumers (as with those who had positive experiences) there was consistency between their initial definition of coordination and their expectations about coordination as part of their transition experience, although they did not actually experience coordination.

CONSUMER 2 (Female, Age 23)

CONSUMER: *He didn't bother because he was more concerned about just getting me out of there. So if I could coordinate whatever, but he just didn't understand that it wasn't that easy. Especially for me being blind.*

INTERVIEWER: *So what kinds of things do you think are important about the coordination of services for people who leave hospital and require care at home, from your experience?*

CONSUMER: *I think there needs to be teamwork, effective and clear team work, like, what am I trying to say. The doctors or nurses, well probably the*

> *doctors, should know what the resources are, even within the hospital, even if all they know is to call social work. They should know what the other options are instead of just handing it over to the patient because sometimes we don't know.*

In the excerpt above the consumer defines coordination as "teamwork" and then goes on to elaborate what teamwork involves. The implication is that coordination as "team work" would have produced a more satisfactory experience for her. The excerpt also provides insight about the limits of consumer involvement, i.e., sometimes the patient doesn't know what to do.

In the next excerpt from the interview with the same consumer it becomes evident that if there is going to be consumer involvement in coordination, the organizational environment and health care providers need to allow and encourage this involvement.

> INTERVIEWER: *Do you think, perhaps, your own health background really helped you in terms of knowing that social work was the place that you should go?*
> CONSUMER: *Well, health and being a social work student, I just know those resources are there. I was going to mention it but he wasn't listening to me anyway so it didn't seem to matter if I had said it or not.*

F. SUMMARY

In the preceding section the construct of coordination from the perspective of the consumer emerges. The "terms" provide insight about what coordination means to consumers. The "components" expand on aspects of coordination that are important to consumers. A consistent and dominant theme is consumer involvement in the

consumer's own care. This involvement begins to emerge in the "components" that consumers identify as important to coordination, particularly "communication with the consumer" and "consumer focus". Consumer involvement is the foundation of the consumer role and the consumer actions that were identified in coordination. Consumer involvement also has an impact on the utilization of health care services. Specific examples of health care system support emerged from the consumers' discussion about important aspects of coordination.

The majority of consumers who were interviewed indicated their care had been coordinated. This was expressed in a number of ways: a) statements indicating that care was coordinated; b) using examples to indicate why the care was coordinated, which provided internal validation for the definitions of coordination that emerged previously; and c) in some cases actually extending the definition or meaning of coordination. One extension was to consider coordination in the wider context of the consumer's environment; the other was coordination as part of the link between health care sectors. Intersectoral linking had three aspects: 1) nurses from one sector (Home Care) going to visit the patient in another sector (hospital); 2) nurses from two different sectors working together at the same time (as opposed to sequentially) to provide the consumer with the necessary services; and 3) facilitating consumer access to services in another sector.

For consumers who did not have a positive transition experience, again there was internal consistency between how they defined coordination and what they expected (but did not experience) in their health care. The definitions of coordination and expectations were similar in the reports among consumers with a positive transition experience , and those with a negative experience. The most obvious difference was that the latter stressed the need for a more holistic approach to their health care, presumably because this was not their experience. An interview with a consumer who had a negative transition experience illustrates the importance of fostering an environment that encourages consumer involvement. One way to do this is to pay attention to what consumers say about their own health and health care needs.

Figure 6 summarises the Meaning of Coordination to Consumers and Figure 7 provides examples of Health Care System Support for Coordination. The relationship between system support and coordination is discussed in Chapter 5.

FIGURE 6

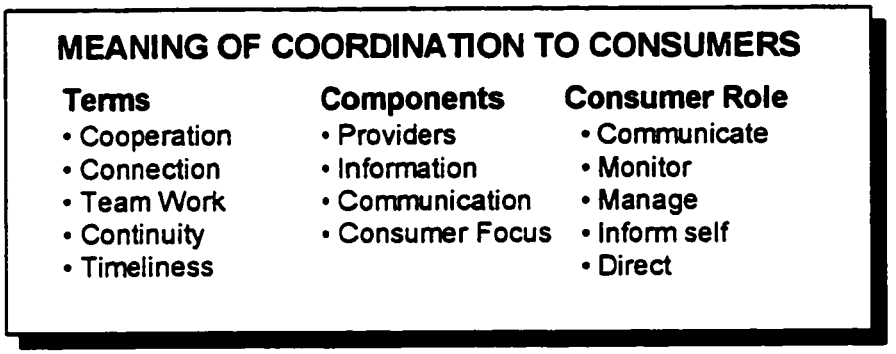
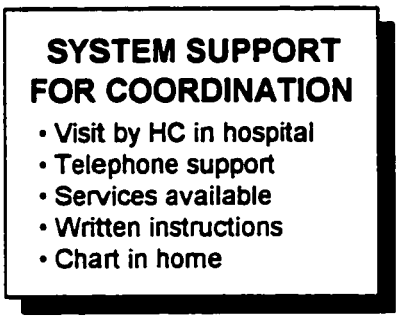


FIGURE 7



IV. THE TRANSITION FROM HOSPITAL TO HOME

A. OVERVIEW OF THE SECTION

Consumers were asked about the transition experience leaving hospital and returning to their homes. Their responses are presented in this section under the following headings: 1) consumer preference (for home or hospital and the timing of discharge from hospital); 2) consumer preparation (for returning home); and 3) the successful transition.

B. CONSUMER PREFERENCE

1. Site - Home or Hospital

Preference for Home

To gain insight about the transition experience, consumers were asked if they preferred to be in hospital or at home. It was hypothesized that consumer preference for hospital care might contribute to the perception of a negative transition experience. This was not the case. The vast majority of consumers (25 of 26 personal interviews) indicated that they would prefer to be at home.

CONSUMER 22 (Male, Age 51)

> *I desperately wanted to get out of hospital and come home so they fulfilled that need for me.*

CONSUMER 34 (Male, Age 66 years)

> *In terms of comfort, I'd far rather be at home in a sense because everything is familiar and there's so many things I can do myself.*

CONSUMER 7 (Female, Age 77)

I don't want to stay. If they could do surgery and send me home the same day I would be home. I hate it.

When consumers were asked where they thought they would get better most quickly, again there was a consistent view that home was better.

CONSUMER 17 (Male, 77 years)

Oh, I'd get better at home. Yeah.

CONSUMER 9 (Female, 79 years)

Oh, more quickly at home.

One consumer (who indicated she preferred to be at home) indicated there would not be any difference in the timing of her recovery.

CONSUMER 16 (Female, 82 years)

INTERVIEWER: *Do you think you will get better faster at home or in the hospital?*

CONSUMER: *I think the progress is good both ways because the treatment was exceptional both ways.*

Preference for Hospital

Only one consumer expressed a preference for the hospital. He needed a walker to move around and liked the hospital because the floors did not have carpet.

CONSUMER 5 (male, age 39 years)

I would have preferred to have been in hospital myself and it's primarily because of movement restrictions, ability to get around, and go longer physical distances than I can in just the upstairs of my house here.

2. Timing of Discharge From Hospital

An issue related to the preference for being at home was the timing of discharge from hospital. Most consumers indicated the timing of their discharge from hospital was about right. This was often part of a positive, coordinated, successful transition experience as is evident in the following interview.

CONSUMER 16 (Female, Age 82)

INTERVIEWER: *Can you tell me about leaving hospital. Did you feel ready to come home? As far as leaving, were you ready?*
CONSUMER: *Yes. They wouldn't release me until they said I was ready.*
INTERVIEWER: *Okay, did you feel ready?*
CONSUMER: *Yes, I think so.*
INTERVIEWER: *So, your preference was to be to be discharged about when you were?*
CONSUMER: *Yes.*

INTERVIEWER: *Okay. How would you describe the transition coming out of hospital and coming home? Would you say that was a positive or negative kind of experience for you?*
CONSUMER: *Positive. Yes, I think so.*

CONSUMER: *The transition was good and the staff both ways have been amazing.*

A consumer who was anxious to get out of hospital was very pleased that the Home I.V. Program allowed him to get the antibiotics he needed without his being in hospital. Although he was actually in hospital somewhat longer than he had anticipated, he seemed confident that the longer hospital stay was needed.

CONSUMER 28 (Male, Age 21)

CONSUMER: *Yeah, it* [Home I.V.] *was giving me antibiotics every 4 hours and that was the same as at the hospital. So basically if I hadn't been able to get that, I probably would have been in the hospital for 4 weeks because it was either be in the hospital or go back there every 4 hours to get the I.V..*

INTERVIEWER: *Do I take it from your comments that your preference was to do the Home I.V. rather than stay in hospital?*
CONSUMER: *Yeah.*
INTERVIEWER: *What about when you came out of hospital? What was your feeling about the timing? Would you like to have stayed in there longer or did you want to get out sooner?*
CONSUMER: *I was pretty bored actually and so I knew why they wanted to keep me in as long as they did but I was anxious to get out.*

Consumer involvement was an important theme that emerged in the descriptions of coordination, and the consumer role was an important aspect of coordination. However, the consumer in this next interview is unique in the very powerful role that he played in the timing of his discharge from hospital. Because his discharge from hospital was delayed, the transition to home was seen as successful by the consumer and his wife. The interview illustrates the interplay between timing and site preference. For this consumer, when he was ready to leave the hospital, his preference was to be at home.

CONSUMER 8 (Male, Age 76)

INTERVIEWER: *Could you tell me about leaving hospital. Did you feel you were ready to come home? Was the timing about right for you? Would you like to have stayed in hospital longer or did you want to get out of hospital sooner ?*
CONSUMER: *No. They, meaning the doctor, would have liked me to be discharged. I had to apply pressure to stay a couple of days longer than they would have liked.*
...
INTERVIEWER: *Okay. So by the time you actually got home did you feel that you were on the mend? You weren't just being turfed out before you were ready to go?*
CONSUMER *No, no. We were ready, when I was discharged, we were in complete agreement with the time and felt that was the right time.*

INTERVIEWER: *In terms of getting better--do you feel that your recovery process has been about the same at home or would it be better in hospital.*
CONSUMER: *Ten times more the recovery-- is 10 times more at home than at the hospital.*
SPOUSE: *May I interject that I think that because he was let out at the right time that it was better. Had it been sooner, no I wouldn't have been able to cope. No.*
CONSUMER: *No, that's right, that's right*
...
CONSUMER: *I emphasized to them that there was no way that my wife could handle the situation at home if I had gone home then.*
INTERVIEWER: *Did you feel that they listened to you? Did you feel that they were really hearing what you had to say?*
CONSUMER: *Well, I wasn't about to move.*
...
CONSUMER: *I appreciated the fact that there were other people there, but like I told them, I figured I was pretty sick myself.*

Despite his rather confrontational approach with the health care system, the consumer characterized the transition from hospital to home as a positive experience.

INTERVIEWER: *And would you call the transition experience a positive experience or a negative one?*
CONSUMER: *Very positive. Very positive.*
INTERVIEWER: *That's great. What kinds of things do you think contributed to the fact that it was positive?*
CONSUMER: *Because we were ready for it.*

The consumer indicated a preference for home but only when the timing was right (from his perspective) for discharge. He was the most dramatic example of a strong consumer role and a successful transition once he felt ready for discharge.

Two other consumers indicated concerns about the timing of their discharge but were not successful in changing the timing. Both consumers were from Home Care Area

2 and were from non-Caucasian ethnic backgrounds.

CONSUMER 25 (Female, Age 77, from Pakistan)

INTERVIEWER: *Okay, so you had an angioplasty. You had that on the 7th and you came home on the 8th?*
CONSUMER: *Yes.*
INTERVIEWER: *So you left hospital the day after your angioplasty.*
CONSUMER: *That's something I asked the doctor. I said, "I have nobody at home, please keep me for another day". They said, "No, there are no beds" and they sent me home. That I don't like, especially after any operation, we would like to stay for a day or two. So I told him, "I don't want to stay in the hospital* [it is] *just because I don't have anybody* [at home] *and I can't come there, you see, if I feel bad or sick".*

CONSUMER 29 (Male, Age 59, from Africa)

INTERVIEWER: *What did you think about the time? Would you have liked to have been in hospital longer or did you want to get out sooner? How did you feel about the time in hospital?*
CONSUMER: *I would have preferred a little bit more time in the hospital.*
INTERVIEWER: *How much longer do you think would have helped you?*
CONSUMER: *At least a fortnight.*
INTERVIEWER: *That would be two weeks in total?*
CONSUMER: *Two weeks.*
INTERVIEWER: *So another week after surgery to get stronger?*
CONSUMER: *After surgery, yes.*
INTERVIEWER: *Tell me more about coming home a bit too soon.*
CONSUMER: *I was okay but I felt that if I had another couple of days or so, another seven days, I would have been better off. I did request of my surgeon if I could stay another couple of days but they said my healing was fine and all this thing plus they needed the bed. So they asked me if there was no problem for me to go. They checked through everything and there was no complication except there was one little problem when they took the bandage off. They just pulled it so my skin came off with the bandage and there was a bruise. So they said okay. I talked to a social worker so the nurse came for three days at home and then it was okay.*

C. PREPARATION FOR RETURNING HOME

Most consumers indicated they felt prepared to come home. This preparation was manifested in a number of ways: a) knowing what to expect when they were discharged; b) having the necessary training to manage at home; and c) written instructions about what to do. Consumers who were prepared to go home often received information more than once and in a variety of formats.

1. Expectations

Part of being prepared was knowing what to expect at discharge.

CONSUMER 16 (female 82)

INTERVIEWER: *Did you feel ready to come home in the sense of being prepared? Did you know what to expect when you got home?*
CONSUMER: *Well, yes. They told me what I needed for equipment and different things and my family was able to provide whatever I needed.*

One consumer indicated he knew what to expect about his medical condition when he returned home because he had been involved in the decision to proceed with his surgery.

CONSUMER 35 (male, 68 years)

INTERVIEWER: *In terms of knowing what to expect, did the doctors explain to you what it would be like when they took this hip out?*
...
CONSUMER: *They explained it to me on several occasions, not just once.*
...
CONSUMER: *Between the 2 doctors, and the talks we had, I'm going to say on at least 4 occasions, before the decision was made to do this* [surgery].
INTERVIEWER: *Did you feel then that you were well informed and that you were involved in making the decision?*
CONSUMER: *That's right. It was strictly my decision.*

INTERVIEWER: *Now when they laid it out for you, what did they explain to you? What did they tell you your options were?*
CONSUMER: *They explained the positive sides of it and the negative.*
...
CONSUMER: *Well, the negative would be, you know, mobility. And, the positive, of course, was getting rid of the constant pain. The pain was terrible. It really was. So I didn't have any problem making up my mind.*
INTERVIEWER: *Is that pretty much what's happened, what you expected?*
CONSUMER: *Really, I'm getting around right now as well as I did when I first came home with the original operation.*
...
CONSUMER: *The pain is gone and it's getting less all the time. It's getting better all the time and easier to move around. I'm exercising it pretty good--two or three times a day.*
INTERVIEWER: *Sounds like you're pretty happy with the decision?*
CONSUMER: *Oh, I am. Very.*

2. Training

Another aspect of consumer preparation was training consumers to manage the equipment or therapy they would need at home.

CONSUMER 22 (Male, Age 51)
They were very thorough in the hospital, schooling me on the pump and what to do, before I left the hospital. What to do if there was a situation that evolved, how to handle it, whatever.

CONSUMER 9 (Female, Age 79)
INTERVIEWER: *Did you feel prepared to come home? Did you know what to do to take care of your leg and that sort of thing?*
CONSUMER: *Well the nurse told me, the Home Care nurse. Oh, yes, I was prepared because I had been down* [to the physiotherapy department] *and I had instructions.*

3. Written Instructions

Written instructions had been identified previously as an aspect of system support that

consumers indicated was related to coordination. Written instructions were also an important and recurrent element for those consumers who indicated they were prepared to come home. Instructions were provided for various stages of the care process but were particularly important at transition points such as prior to hospitalization and the day of discharge.

Prior to hospitalization.

CONSUMER 9 (Female, Age 79)

I understand that previous to my experience, years ago, you went into hospital 2 or 3 days or a week before, and they told you what was going to happen. But now you receive it as printed material and you can study it at your leisure. Also, it tells you exactly what to do at each step of your surgery, either before or afterwards.

The day of discharge

CONSUMER 29 (Male, Age 59)

Yes, they were written down for me and they wrote, before discharge at one o'clock, what medicine I already had so when I come home I should not repeat it. They wrote it down, everything. Prescription was given. What exercises I should be doing.

4. Multiple Methods

Consumers who felt prepared to go home had often received information more than once in a variety of formats to reinforce the message, had been given guidance about how to handle anticipated problems, and had a phone number to call as a backup.

CONSUMER 14 (Female, Age 50)

INTERVIEWER: *So they tell you what you needed to know?*
CONSUMER: *Oh yes. Obvious things--no lifting, no heavy duty things. Actually they give you a sheet.*
INTERVIEWER: *Okay, so written instructions too.*
CONSUMER: *Oh, you do get written--I mean, it's minimal instructions but they are written down so that you've got a backup in case you do forget what they tell you.*

CONSUMER 22 (Male, Age 51)

They gave me a complete folder everything--what to do if--if--if--
If this happens, if this happens, if this happens. And if none of that worked then I was to call immediately.

CONSUMER 28 (Male, Age 21)

CONSUMER: *Everything about how to use the pump, and how to change the lines myself, and change the bags each day, and everything they gave me.*
INTERVIEWER: *So that was written down. Was that helpful for you that it was written down?*
CONSUMER: *Yeah. And they gave me all the phone numbers that I needed and everything.*

D. THE SUCCESSFUL TRANSITION

This section examines what contributed to a successful transition for consumers in the transition from the hospital to receiving care in their home environment.

1. Support

Support emerged as a very important part of the transition process. As the study progressed, the interview guide was modified to ask consumers if they felt they had support at home and to explore what contributed to a feeling of support. Consumers

identified a number of sources of support including: family members, the community and the health care system.

Family member support

CONSUMER 35 (Male, Age 68)

INTERVIEWER: *What about coming home? Did you feel you had enough support to come home?*

CONSUMER: *Oh, yeah. Because all my three children are here. And all of them are dedicated kids.*

CONSUMER 7 (Female, Age 72)

I really didn't have that much care at home after I came out of the hospital. My nurse is there [pointing to husband]. *He fills the syringes, he does everything, and once a week the Home Care comes.*

Community Support

CONSUMER 34 (Female, Age 66)

INTERVIEWER: *What about support? Do you feel that you have enough support at home to manage at home?*

CONSUMER: *Oh, I think so, and I've got good neighbours. My neighbour next door comes in almost every day. And she sweeps the floor if it needs to be swept or whatever--she just is a good friend.*

System support

Excerpts from the following interview illustrate a number of aspects of health care system support. The right kind of care was provided, the care was good and appropriate, and only services that were needed were provided.

CONSUMER 14 (Female, Age 50)

Right kind of care:
INTERVIEWER: *Anything in particular about coordination in the health care area?*
CONSUMER: *Like I say, it seems to be working. If every patient is the same as I am, it worked great. I mean, the coordinator came in to see me the day before I was discharged and the day of discharge, so I saw her twice. And obviously, you know, she talked to the doctor and the nurses in charge to see what he wanted, you know, what needed to be set up at home. And it was all set up.*

Good care provided at home:
CONSUMER: *I think the level of care at home is as good as it is in the hospital. The only difference is that it's not 24 hours.*

Appropriate level of care provided:
INTERVIEWER: *Was your feeling that for your situation care was appropriate?*
CONSUMER: *Oh, yes. I needed 24-hour care when I went back into the hospital.*
INTERVIEWER *Okay, ... you mentioned you don't seem to need the care 24 hours a day.*
CONSUMER: *I need somebody that knows what they're doing to come in. But even as far as, you know, moral support, if there was something else going on, they are there for that as well.*

Services available but not automatically provided:
CONSUMER: *Well, if you need extra help, another portion of home care* [is available] *if you do need the extra help.*
CONSUMER: *It's there and it is available but it's not something that's kicked in automatically.*
INTERVIEWER: *So, it sounds like you think - it's a good idea that you get what you need. You don't get everything automatically, you get what you need.*
CONSUMER: *Well this is it. If you need it, it's available. To me, that works great because it's not wasted.*

This idea of resources being available was evident in other interviews.

CONSUMER 22 (Male, Age 51)

CONSUMER: *I mean, to me it was great getting out of the hospital and still having the resources at hand if I needed them.*

Telephone Contact: Another very important source of system support identified by many consumers was telephone contact.

CONSUMER 28 (Male, Age 21)

I had all these phone numbers. And I phoned back, I phoned to the Home Care nurse, actually. And she gave me everything she could think of to do. Then she said, well, I'll give you 2 more things to do and if neither of these work then you'll probably have to come back up here and I'll look at it.

2. Confidence

One of the aspects of the transition process that was examined was whether the consumer felt confident about the transition and what contributed to confidence. Confidence seemed to be related to system support and to preparation.

Confidence and System Support

CONSUMER 28 (Male, Age 28)

INTERVIEWER: *You were saying you felt pretty confident managing things at home. You had the written stuff, and they'd gone over it with you, and they'd taken X-rays.*

CONSUMER: *Yes. The Home Care Nurse was really helpful too. She checked my toe each time she came and made sure it looked like it was getting better.*

Confidence and Preparation

CONSUMER 8 (Male, Age 76)

CONSUMER: *I was looking forward to it* [going home] *and I was very confident. It was the right thing-- that day. But I didn't before.*
INTERVIEWER: *Why was the transition from hospital a positive experience?*
CONSUMER: *Because we were ready for it.*
INTERVIEWER: *And what were some of the things that contributed to readiness? What helped you to be ready do you think?*
CONSUMER: *My condition. Because I had done a considerable amount of walking and exercise, well no, just walking, which prepared me for it.*

Control

For one consumer, control had emerged as a significant issue related to the timing of his discharge from hospital. Therefore, other consumers were asked about their feeling of control to explore if this appeared to contribute to their feeling of confidence. Control did not emerge as a major issue.

When consumers who had indicated the transition was positive were asked if they felt in control, they usually answered yes, but the responses did not reveal much about the concept of control.

CONSUMER 31(Male, Age 51)

INTERVIEWER: *Did you feel pretty much in control of things about coming home?*
CONSUMER: *Oh Yeah.*

Although consumers often answered "Yes" when asked about control, their responses suggested that it was other factors that were actually important. For example, in the next interviews, consumers answered "Yes" when asked if they felt in control but their responses suggest communication, not control, was the central issue.

CONSUMER 35 (Male, Age 35)
Yes. I understood the picture. Only through good communication with Dr. F. and Dr. H.
CONSUMER 28 (Male, Age 21)
Yeah. I was really surprised, actually, how much they did tell me and how much I was involved in everything.

3. Functioning At Home

The key issue in the success of the transition process was how well the consumer was able to function at home. Factors that contributed to functioning at home included support (from the same sources that emerged when examining support independently) and confidence.

Functioning and Family/Community Support

CONSUMER 35 (Male, Age 68)
INTERVIEWER: *Are you living on your own?*
CONSUMER: *Yes.*
INTERVIEWER: *So do you do your own cooking and that kind of thing?*
CONSUMER: *Yes.*
INTERVIEWER: *Are you managing that?*
CONSUMER: *Yes, and well, really, I think at least 50% of the time, the kids will either bring me a hot supper or I do have a good friend from the community that spoils me rotten.*

Functioning and System Support

CONSUMER 12 (male, 61 years)

INTERVIEWER: *Okay, and the kind of Home Care you were getting was nursing?*

CONSUMER: *Yes, changing all the I.V.'s, that was really all there was. They asked me if I wanted help with bathing or anything like that but with these bars in there it's no problem. I didn't ask for the bars. They asked me if I wanted them which was great. I got a raised toilet seat.*

INTERVIEWER: *So these things make it possible for you to manage on your own basically.*

CONSUMER: *Oh, yes. When my wife works late or something like that, there's no problem.*

Functioning and Confidence

Confidence seemed associated with functioning well at home. In the next examples, two consumers who did well at home indicated they felt confident about going home.

CONSUMER 9 (Female, Age 79)

INTERVIEWER: *You were saying you felt quite confident coming home.*

CONSUMER: *Oh, yes, I had no problem. I thought I could manage quite a bit.*

CONSUMER 7 (Female , Age 72)

INTERVIEWER: *So did you feel confident coming home?.*

CONSUMER: *Oh sure.*

INTERVIEWER: *With your husband here to help.*

CONSUMER: *And even before, when he was working, I was home by myself all day. I was okay. When I was tired I would lay down.*

In contrast, a lady who would have liked to stay in hospital longer was not confident about going home alone so she stayed with her son and his family until she was able to return to her own home.

CONSUMER 25 (Female, Age 77)

INTERVIEWER *So, did you feel ready to come home on the 8th?*
CONSUMER *No, it was too soon. Another day or two would have helped me.*
INTERVIEWER *You would have felt stronger ?*
CONSUMER *And more confident.*
INTERVIEWER *So when you did come home, did you feel confident coming home?*
CONSUMER *No, I had to ask my son. And my daughter-in-law came and picked me and I was there for four days in his house.*

E. SUMMARY

All consumers except one preferred to be at home. Despite this clear preference for being at home, there was variation in consumers' experiences about the timing of their discharge from hospital. Although most consumers agreed with the timing leaving hospital, the two consumers who felt they were discharged from hospital too soon were from ethnic backgrounds other than Caucasian.

Preparation to return home after hospitalization is part of a continuum of care. Consumer involvement in decisions about treatment that requires hospitalization (e.g., surgery) is the first step in preparation. A consumer who was involved in making the decision about his surgery felt he knew what to expect post-operatively when he got home since this was part of the discussion about likely outcomes. The preparation continues with training (while the consumer is in hospital) about procedures that will be required at home. Consumers indicated that good preparation went beyond just

explaining how to do certain exercises or technical procedures; it also provided information about possible common problems and their solutions. A powerful tool that empowers consumers are written instructions at different phases of the continuum of care: before hospitalization, during hospitalization in anticipation of Home Care, and on the day of discharge. Repetition in conveying information in a variety of formats was perceived as effective preparation. This included: a) verbal explanation; b) technical or hands-on training about equipment or exercises; c)written instructions; d) anticipating common problems; and, finally, e) a telephone number to call if there were additional problems.

The key aspect of a successful transition was how well consumers were able to function when they arrived home. There were two factors that appeared to be related to functioning well: 1) confidence - which was related to preparation and support and 2) support - from the same sources that emerged when examining support independently (i.e. family, the community, and most importantly for functioning, from the health care system). Although system support was very important and consumers indicated they wanted to have the right kind and amount of care available, they did not want everything automatically put into place unless the care was actually needed.

Figure 8 and Figure 9 outline the elements of Preparation for Returning Home and a Successful Transition Experience. The relationships between these two aspects of the Findings is discussed in Chapter 5.

FIGURE 8

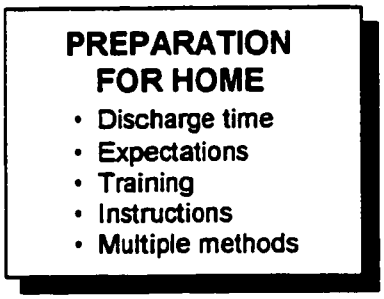
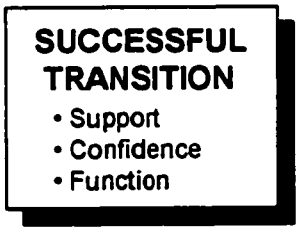


FIGURE 9



V. HEALTH CARE SERVICES

A. OVERVIEW OF THE SECTION

The health system activities that emerged from consumers' discussions about coordination are presented in a previous section on "The Consumer's View of Coordination" under the heading "Coordination and the Health Care System" (Chapter 4 - Section III. D.). Aspects of health care system support are also captured in the section on "The Transition from Hospital to Home" under "Preparation for Returning Home" and "The Successful Transition". (Chapter 4- Section V.C. and D.)

Consumers were asked structured questions about their transition experience to elicit information about coordination, including whether they noticed any gaps or duplications in the health services they received as they left hospital and returned to their homes. The responses to these questions related to coordination are included in the previous section on "Coordination and the Transition Experience" (Chapter 4 - Section III. E.). The balance of the responses to these questions are contained in this section under the headings "Gaps in Services" and "Duplication of Services".

This section also contains consumers' spontaneous comments about health services generally and responses from the last three consumers interviewed in person who were asked about the reorganization of health services.

B. CONSUMERS' VIEWS ABOUT SERVICES

1. Gaps in Services

Introduction

The majority of consumers indicated there were no gaps in care or services between the hospital and Home Care. There were, however, a few gaps identified by individual consumers. Usually there were only one, or possibly two consumers who identified a problem, so the following examples do not represent recurrent themes, but they do identify some areas for further investigation.

No Gaps

The following is typical of the consumers' responses about gaps in services.

CONSUMER 22 (male, 51 years)

INTERVIEWER: *Did you feel there were any gaps between the services that you had in hospital and at home?*

CONSUMER: *None at all. The woman who gave me my orientation in the hospital, I know that's all she does, work within the hospital getting people ready for the Home Care, was very thorough and she didn't miss a thing.*

Gap - Financial Penalty for Going Home

The consumer in the following excerpt was pleased to be able to go home with the I.V. rather than stay in hospital. However, she felt there was an unfair financial penalty involved since she was actually saving the system money by going home sooner. One other consumer also identified a concern about the cost of services at home.

CONSUMER 4 (Female, Age 35)

INTERVIEWER: *Did you like the option of being able to come home?*
CONSUMER: *I did. Very much. It was a big decision though because of the price. Unfortunately, they don't make it easy for you to come home. You think it's cheaper for me to be at home than it is to stay in the hospital but they pay a certain percentage but they don't pay it all so it still worked out to be quite a lot of money to have to pay for I.V. bags and other things that you don't have to pay when you're in the hospital. A lot of it depended on how much the cost was going to be if it would be even worth it but we decided to go ahead anyway even though it was a bit expensive for us. I could see where people who weren't in that financial situation would have no option. They would have to stay at the hospital.*

Gap - Lack of Staff Support for Services Offered

The consumer in the following interview indicated that she was well prepared by the Home Care nurse while she was in hospital to manage her I.V. at home. However, she had difficulty getting assistance when she ran into problems with her I.V. at home. There were two problems: 1) the Home Care number that she had did not have someone available 24 hours a day to deal with the I.V.; and 2) the emergency room where she was sent did not have staff (doctors or nurses) who knew how to deal with a mid-line I.V. problem. This "gap" that this consumer experienced affected her definition of coordination. As a result of her problem, one of the components she identified as important for coordination was that trained staff should be available if a service is offered.

CONSUMER 4 (Female, Age 35)

The only problem I ever had was just at the end. I had a lot of pain in my arm and they had said when that happened to phone right away because probably something was wrong with the midline. That was confusing because nobody sort of knew where they were supposed to be at that time. I ended up having

to go to Emergency and the Emergency doctors had no clue as to what they were supposed to do with me. I had to borrow their phone and phone Home Care. It was at night so my particular one, the one I was assigned to, wasn't there. What ended up was they finally ... the doctors just pulled the midline - just took it out and put in a regular I.V.

Of the eight consumers who were receiving Home I.V. treatment, only two reported a lack of support when they encountered problems These consumers were interviewed early in 1996 (January and April). Consumers who were interviewed later in 1996 were very satisfied with the support they received for their Home I.V.

Gap - Lack of Services Available

The consumer in the next interview lives in a rural area that is now part of the CRHA served by Home Care Team 7. (See Figure 5). In her view, there should be more therapy services available in her area. The therapist that serves the area works only two days per week and this lady finds that the therapist does not have enough time to provide the therapy that the consumer feels she needs.

CONSUMER 15 (Female, Age 82)

INTERVIEWER: *Do you feel that you've had enough support in terms of the nurse and the therapist coming?*

CONSUMER: *I do feel that* [the therapist working] *two days a week is not enough. I would like to see her once a week and have her work with me but she can't do it, with that many people.* [This consumer was seen by the therapist about once every two weeks.]

Gap - Infection Control

Although the question about gaps in services was directed at the transition from hospital to home, one consumer identified what she believed was a gap going from home to hospital.

CONSUMER 7 (Female, Age 72)

INTERVIEWER: *Did you feel that there were any gaps in the kinds of services you were getting coming home from the hospital, any things that you would have liked to see happen that didn't?*

CONSUMER: *There is only one thing wrong with all those cut backs because that's okay the cut backs. What's wrong with that, I told the Doctor, that's how you get, I'm pretty sure, the infections, before you get to surgery. The day before, the last time you go when they take all those tests, they give you a little bottle with soap, disinfectant soap they tell you to take a shower the day before or the morning of your surgery and wash the parts of you good. Okay, you do it but then you put your street clothes on again. Even if they are washed there is always germs there.*

SPOUSE: *And that's completely wrong, they should still do that in the hospital before you go to surgery take a shower and wash it with that disinfectant soap and then go into--.*

CONSUMER: *That's what everybody is talking about. There was another lady after we came back in February, she had a little thing taken off her foot, she had infection too. She was on the pump for six weeks. And that's what she says too. She says, it's just because everything is, that way, more or less neglected.*

It is the perception of this couple and their friends that there has been an increase in post operative infections.

Gap - Follow Up / Continuity

There were two consumers who identified a problem with continuity. One was a woman interviewed by telephone who had only three visits from Home Care. After

her last Home Care visit she had a problem and would have liked to speak with the nurse. Because her chart was gone, she was not able to call the nurse. This consumer would have appreciated having a Home Care telephone number to call.

The other consumer had a heart transplant in Edmonton but was hospitalised a number of times in Calgary and followed by Home Care in Calgary due to recurrent infections. He indicated that each time he started with Home Care he seemed to have a new file and had to repeat his history and medication list for each new Home Care nurse. His suggestion was to have one file which would be used for all his Home Care visits.

2. Duplication of Services

Consumers were asked if they experienced any duplication or overlap in resources or services and consistently consumers answered "no". Only two consumers indicated there had been any overlap or duplication.

One consumer had been hospitalized in the United States.

CONSUMER 18 (Male, Age 23)

INTERVIEWER: *Did you feel there was any duplication? For example did you have to have a battery of tests that had already been done?*
CONSUMER: *A little bit but it was understandable. Mostly the visual stuff. They did an echocardiogram and an EKG for their eyes.*
INTERVIEWER: *Did you feel there was too much testing?*
CONSUMER: *No, I was glad they did that. Just so they knew what was going on.*

In this case, although there had been some repetition of certain tests, the consumer viewed this as appropriate, not unnecessary duplication.

For another consumer, both the Home Care nurse and the doctor in hospital checked his foot for signs of infection.

CONSUMER 28 (Male, Age 21)

> *The only thing that I really noticed was, like I had to go back in every week after I got out of the hospital for blood work and I was supposed to go and see Dr. W. and he'd check my foot and everything. So the only thing was the nurse would check my foot every three days or whatever* [at home] *and then Dr. W. would too* [in the hospital] *but I think that was more just to make sure things were getting better and not worse.*

This consumer was seen every three days by a Home Care nurse as part of a Home I.V. Program. As well as attending to his intravenous, the nurse also checked his foot which had been severely infected and was the reason he was on the Home I.V. program. When the consumer went in to have blood work done on a weekly basis, the doctor also checked his foot. He viewed this as some duplication, but it involved very little inconvenience to him: *"All they did was just take my sock off".*

3. General Comments About Health Services

Consumers also offered unsolicited comments about health services in the region. Although these comments do not relate specifically to coordination, they are included here for completeness.

There were frequent comments about nurses in hospitals working too hard. The Home Care nurses were perceived as busy, but not as rushed with individual patients.

CONSUMER 16 (Female , Age 82)

The care in the hospital was amazing under the conditions that they're operating. The nurses are terribly short-staffed and yet they were amazing, really they were.

CONSUMER 35 (Male, Age 68)

But in the hospital they're rushed. They don't take enough time....
But with Home Care it's different. They're here to see me and they're here for a half an hour

CONSUMER 7 (Female, Age 72)

Well, as far as in the hospital, you are well looked after. The girls are too busy. They've got too darned much to do

These and similar comments imply that consumers found that although the care they received in hospital was good, the nursing staff was overextended.

In general, consumers' experiences were positive and reinforced the information that emerged in response to questions about the transition experience.

CONSUMER 22 (Male, Age 51)

Well, to be honest, I think we've covered it because ... I couldn't praise them enough - the Home Care - they were just excellent. The transition from hospital to home and from home to getting on my feet was excellent. The communication was excellent. The coordination was excellent. I was just so glad they were there. I got to get out of that hospital and be at home and be among the familiar things and things I wanted to do and could do and they helped make that transition possible.

4. The Reorganization of Health Services

During the course of the study, there were changes in the organizational structure of the CRHA (See Chapter 3 - Setting). A significant change relating to Home Care occurred in April 1996 when Home Care was moved from the Public Health Sector to the Continuing Care Sector. The impression of managers working in Home Care at the time (personal communication) was that this administrative change had very little impact on clients receiving Home Care services. Consumer awareness of the organization of Health Care Services did not spontaneously emerge during the interviews. Near the end of the study, the last three consumers interviewed in person were explicitly asked about their impressions of the reorganization of health services and if they were aware of any effect that these changes had on their own health care.

CONSUMER 35 (Male, Age 68)

INTERVIEWER: *Are you aware of any of the changes that are taking place in health care?*

CONSUMER: *No, not really, because, well a year ago was my introduction to health care, and Home Care especially. I didn't realize the things that were available.*

INTERVIEWER: *Do you feel that your health care, for you as an individual, has been affected at all by any of the changes?*

CONSUMER: *Well, not really, you know. Health care is a touchy subject with a lot of people. Personally, I think as an Albertan, I probably got as good a health care treatment as you can get anywhere.*

CONSUMER 34 (Female, Age 66)

INTERVIEWER: *What about changes in health care and the way health care is provided or delivered? Do you think there will be any change for you personally, that your health care will be affected by these changes?*

CONSUMER: *I'm not too sure but the way I look at it health is most important so I'll probably do something. We'll take care of ourselves regardless of what Mr. Klein or any of the rest are doing.*

CONSUMER 37 (Female, Age 75)

INTERVIEWER: *There's a lot of information around about changes in health care. Have you been aware of any changes?*
CONSUMER: *Oh, yeah. There's a lot of talk about it. We don't discuss it too much.*
INTERVIEWER: *Do you think that it's had any impact on your own care?*
CONSUMER: *No, I don't think so.*

INTERVIEWER: *We're just talking about the Hospital Boards. Tell me again about your views about having only one board instead of a board for each hospital.*
CONSUMER: *As I said, I'm only an old lady talking but I feel that the basic idea is a good one.... So that instead of this having a board, that having a board, this one over here having a board, why can't one well-versed board do all that?*
INTERVIEWER: *Do you think that in theory that should help make it a more coordinated system?*
CONSUMER: *I think so, yes, because then there's not so many, as I always put it, the left hand not knowing what the right hand is doing. If there was one main board, they should all know within that board what's going on, shouldn't they?*

None of the three consumers reported noticing any changes in their own health care. One consumer suggested that a single board rather than multiple boards had the potential to improve coordination.

C. SUMMARY

When asked, individual consumers identified a few specific gaps in services. These concerns were identified by individual consumers and did not represent recurrent themes about problems. However, they do suggest areas for further investigation and action. Only two consumers indicated any overlaps. They viewed these as minor inconveniences and felt the duplication was indicated in the interest of good care.

As a general comment, consumers expressed concern about what they perceived as under-staffing in acute care hospitals. Consumers generally were pleased with their Home Care Services. The three consumers who were asked specifically about changes in the organization of health services were not aware of any changes that had affected them personally.

VI. CONSUMERS' RESPONSES TO THE LITERATURE

Alter and Hage (1993) suggest the following objectives of coordination for programs, resources and consumers in a system: comprehensiveness; accessibility; and compatibility. At the end of the interview, consumers in this study were asked if these categories were part of, or related to, coordination and important to coordination.

A. ACCESS

Questions - Is being able to get health care a part of (or related to) coordination? Is it important to coordination?

The majority of consumers agreed that access was related to coordination. Often, however, they answered just *"Yes"* without much elaboration. Some of the comments which were elicited about how access is related to coordination include:

CONSUMER 1 (Male, Age 29)

> *I guess that's part of it because if I didn't get the care here* [at home] *then it wouldn't be coordinated.*

CONSUMER 28 (Male, Age 21)

> INTERVIEWER: *Now, we were talking about access to care. Do you think that access to care is related to coordination.*
> CONSUMER: *Yeah, like ah, especially with the I.V., and they're always saying there's a shortage of beds or whatever. I think with being able to get out of hospital like that, it does free up beds for other people, plus it gives you a little bit more mobility and everything. That was one thing. And they do coordinate it. They seem to coordinate it really, really well.*
> INTERVIEWER: *Is it important? Is it an important part of coordination, do you think?*
> CONSUMER: *I think so.*

There was a substantial number of consumers who indicated access was not related to coordination.

CONSUMER 5 (Male, Age 39)

I can't relate the two items. Access-wise, once you're pencilled in a slot for the care-giver, you're there. Coordination, I think, is more whether or not the care-giver themself has gone off and done their homework.

There were consumers who indicated access was an important idea but not a part of coordination.

CONSUMER 3 (Male, Age 67)

I don't think it is coordination, but in any case, it is important.

Some consumers did not know.

CONSUMER 12 (Male, Age 61)

INTERVIEWER: *Generally, when you think about access or being able to get services, do you think that's something that's a part of coordination?*
CONSUMER: *I don't really know to be honest with you but like I said I've never had any problem.*

One consumer who had been hospitalised in the United States and was returning home to Canada for follow up care suggested it was not really an issue for him

CONSUMER 18 (Male, Age 23)

I guess I took that for granted - obtaining care - because I got great care. As far as obtaining care, ... I knew the care was there because of the universal health care and so forth, so I was concerned more about the continuity than obtaining.

B. COMPREHENSIVENESS

Questions - Is complete care (being able to get all the health care you need) related to coordination? Is it important to coordination?

The majority of consumers agreed that comprehensiveness of care was related to and important to coordination. With some consumers the answer was *"Yes"* with very little elaboration. For some consumers the answer was *"I guess so"*. Some of the comments associated with yes include:

CONSUMER 14 (Female, Age 50)

I think partially because, like I say, if I needed help with the house, with housework and that type of thing, they would get onto it, you know, the different branches and arrange it for me. I guess to that extent it's coordinated through whoever is coming in for Home Care.

When asked to elaborate most consumers would refer back to their own experience.

CONSUMER 28 (Male, Age 21)

With these little pumps and everything, they have all the different things that you need basically. You can just go out of the hospital and basically get the same care or whatever as if you're in there.

CONSUMER 16 (Female, Age 82)

INTERVIEWER: *What about the idea of completeness? That all the care that you need is available for you. Is that part of coordination?*
CONSUMER: *Oh I'm sure it is. I couldn't have asked for anything more from them I don't think.*

In responding to the questions about the Alter and Hage categories, consumers would often refer back to their personal definition of coordination.

CONSUMER 18 (Male, Age 23)

Yes, absolutely, because if it's not complete, then it's not really - it can't be continuous. (Continuity was part of this consumer's definition of coordination)

There were a significant number of consumers who did not feel that comprehensiveness was related to coordination.

CONSUMER 5 (Male , Age 39)

That's more just a direct reflection on the particular professional you're dealing with.

C. COMPATIBILITY

1. Between Sites (Alter and Hage - Congruence in Expertise)

Questions - Does having the care you receive at home fit with the care that you received in hospital relate to coordination? Is this important to coordination?

Again the majority of consumers agreed that a fit between the care they received in hospital and care a home was related to coordination. Often it was just *"Yes"* without much insight as to why. With probing, a few offered more information.

CONSUMER 14 (Female, Age 50)

Oh, yes. I mean, you can't have both going off at different angles.

CONSUMER 22 (Male, Age 51)

Yes. The woman who set everything up in the hospital - her name was G. - she had everything down. They knew exactly what was going on, the difference being at least I was at home but I was getting the kind of care I was getting in the hospital.

CONSUMER 28 (Male, Age 21)

Yeah, I think that the nurses at Home Care know what things or precautions they were taking at the hospital and she kind of kept that up.

Some consumers viewed the activities of hospital and home as so different that compatibility or coordination between the sites was not seen as an issue.

CONSUMER 17 (Male, Age 77)

INTERVIEWER: *And what about consistency or fit? The idea that what goes on in hospital fits with what goes on at home. Is that a part of coordination, do you think?*

CONSUMER: *To a degree. Not entirely. They are two different aspects.*

CONSUMER (Female, Age 77)

CONSUMER: *Well, after all, hospital is hospital. Every four hours, every three hours, they come and take your pressure and everything, then you're serious and sick. Otherwise, there is no need to take pressure every time.*

INTERVIEWER: *So does that mean what they do in hospital is different than what they do at home?* [Consumer Nods] *Okay, is that related to coordination?*

CONSUMER: *No*

One consumer distinguished between the knowledge that providers in the hospital would have versus those in Home Care. She indicated that hospital staff would not know about Home care. However, Home Care being knowledgeable about the care in hospital would be related to coordination.

CONSUMER 37 (Female, Age 75)

CONSUMER: *No, because do you really feel that what they're doing here at home, the hospital knows anything about it?*

INTERVIEWER: *So, do you think those are two separate things?*

CONSUMER: *Two separate issues. I mean once you leave that ward, they've done all they can there. So from here on we go to the next step, eh?*

INTERVIEWER: *Alright. And what about the people at home knowing what you've had in hospital? For example, understanding what your hospital*

experience has been. Do you think that would be related to coordination?
CONSUMER: *Yeah.*

2. Between Providers and Consumers

(Alter and Hage - Congruence with Consumer)

Questions - Is coordination related to having the people who provide your health care agree with you about your health care ? Is this important to coordination?

Many consumers just said *"Yes"* when asked if providers agreeing with consumers was related to coordination. Some consumers gave a reluctant, *"I think so,"* or *"I guess so"*. A few consumers offered an explanation about why agreement between providers and the consumer contributed to coordination.

CONSUMER 18 (Male, Age 23)
Yes, I do. I think that has a lot to do with coordination because of the inter-patient relationship with the health care professionals.

For some consumers there was an *"it depends"* answer.

CONSUMER 34 (Female, Age 66)
Some people could be too demanding and some could be not demanding enough. So it probably depends on the personality of the person.

There were a number issues that arose in response to the question about agreement between providers and consumers which reflected the components of coordination that emerged in the previous section. The first was the importance of including the consumer.

CONSUMER 22 (Male, Age 51)

Yes, I think so. I asked them about everything and they were very thorough. They had all the information at hand. I never got an "I don't know" or "I'll get back to you on that". They always had everything pretty well under control.

CONSUMER 2 (Female, Age 23)

Yeah. And it goes back to the fact that the social worker at the hospital also called in physio, and when I was talking with the physio, she had some different ideas than the physio for home care, and because of that I got very confused because I heard about four or five different opinions as to how hurt my ankles actually are and how much pressure I should be putting on them. It was hard because all the professionals seemed to agree with one another, or they'll listen to one another, whereas the patient often gets left out

The next aspect elaborates on the previously identified component of coordination - communication. For this consumer, discussion between providers and the consumer is important so the consumer understands decisions that are made. With communication, there can be agreement between the providers and the consumers.

CONSUMER 28 (Male, Age 21)

And instead they had me in there for the ten days. And then when they told me why I was in there, then I knew. It does make you feel a lot better. It is, I think, a big issue - the fact that they do fit together - and then if it is something different, or at least that they can explain it to you like they did to me, why it's different, why your two views are different, or whatever.

Some consumers expressed agreement with the question about compatibility in terms of providers being sensitive and adjusting to their needs.

CONSUMER 4 (Female, Age 35)

Yes, I think so. Because that was the whole idea behind getting it was my needs ... you know, to go home to be with my family. I'd been there long enough and stuff like that.

CONSUMER 14 (Female, Age 50)

Well, like I say, she adjusted her schedule as far as what time she was going to come in to what I needed.

The role of the consumer in coordinating care was a theme identified previously and emerged in the answer to this question as well.

CONSUMER 5 (Male, Age 39)

Yeah, I think what it comes down to is who's the coordinator. And the coordinator seems to be me, the customer, because nobody seems to have gotten hard direction, for example, from my doctor. I'm not criticizing the doctor or anything but essentially there is nobody giving direction as to what may or may not be done to me.

D. SUMMARY

The majority of consumers who were interviewed agreed that the Alter and Hage's (1993) categories of access, comprehensiveness and compatibility were related to, and important to, coordination. There were many instances, however, in which consumers indicated these categories were not related to coordination or did not answer the question.

In responding to Alter and Hage's categories, many consumers, whether they agreed or disagreed, related the question to their own experience rather than answering in the abstract. Therefore, one needed the background information from the interviews to interpret consumers' responses to the coordination categories. There was internal consistency between the early part of the interviews about coordination and the subsequent questions in this section about the literature.

CHAPTER 5: DISCUSSION

I. OVERVIEW OF THE CHAPTER

The summaries at the end of the "Findings" (Chapter 4) in the sections on "The Consumer's View of Coordination" (Ch. 4 - Section III. and "The Transition From Hospital to Home" (Ch. 4 - Section IV.) contain the initial elements of the theory that has emerged from this study. These include the aspects of coordination that are important to consumers and features of the transition between hospital and home that consumers identified as useful. This chapter extends the information provided in the "Findings" Chapter in two ways: 1) text which explains more about these relationships among the various findings, and, 2) a model which integrates the sections in the findings and identifies a series of propositions.

This chapter then examines the consumer's role in coordination in more depth, since this emerged as a major finding. The relationship of the findings to two key organizational constructs in the literature--coordination and clinical integration--is reviewed next. This leads to a discussion about the relevance of the findings to assessing health system performance and to an expansion of an existing model for assessing integrated delivery systems. The final section addresses aspects of the study itself including research quality as well as its limitations, strengths and application.

II. THE THEORY--RELATIONSHIPS AMONG THE FINDINGS

A. THE MEANING OF COORDINATION TO CONSUMERS

There were inter-relationships among the various aspects of coordination: terms, components, and the consumer's role and actions related to that role (See Fig. 6 p.88).

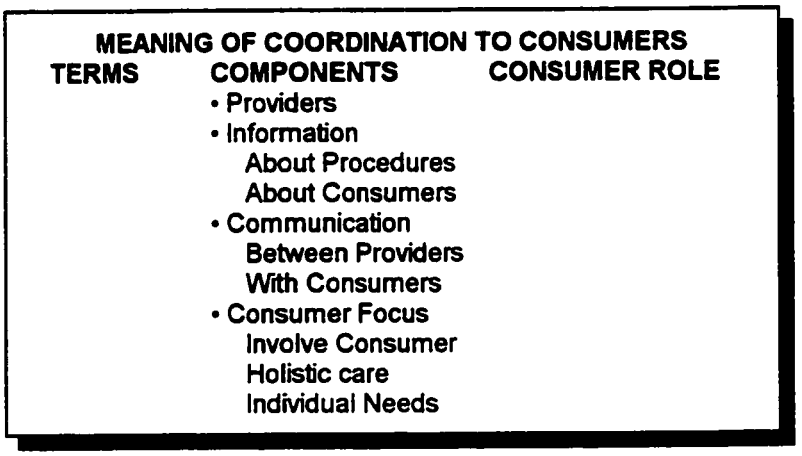
The meaning of coordination to consumers that emerged from the study included specific terms that were synonymous with coordination. The individual terms could be clustered into two groups: 1) there were terms that referred to coordination between providers--cooperation, team work, and connection; 2) other terms related to the processes of care: continuity and timeliness.

The multi-faceted "Components of Coordination" emerged consistently from the interviews with many consumers (see Chapter 4 "Findings" for details). The components were related to the terms--for example, the component "Providers" is related to the term "Teamwork".

The components were also closely related to each other (see Figure 10). This is particularly evident for the components "Communication" and "Information". For example, one aspect of "Communication" relates to "Providers" i.e. communication among various providers. Another example is that "Information" about the individual consumer and "Communication" with the consumer is needed to achieve the sub-

category of "Consumer Focus" identified as recognizing 'individual needs'.

FIGURE 10
COMPONENTS OF COORDINATION

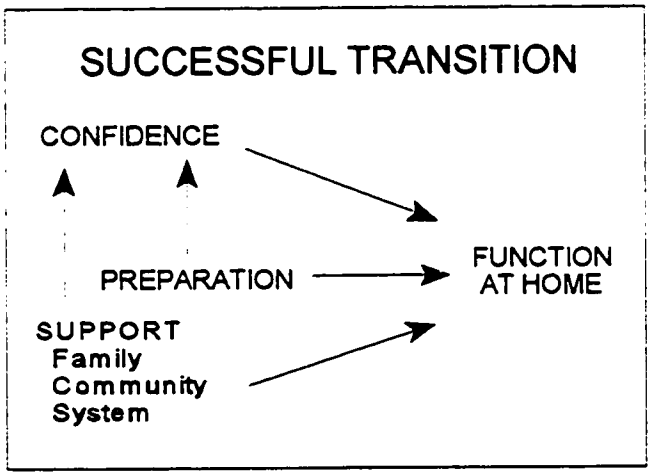


In this study, the role that the consumer played as an active participant in coordinating care involved a number of specific actions: communicate, monitor, manage, inform self, and direct. These consumer actions were also related to coordination components. For example, for the consumer to perform her action role and "Communicate" with the nurse about changing her dressing, there first needed to be "Communication" from the doctor to the consumer and a "Consumer Focus" which were both identified as components of coordination.

B. THE TRANSITION EXPERIENCE

The findings identified a number of sources of support (family, community and the health care system) as important in helping consumers to return home. Figure 11 is a diagram of the relationships that are hypothesized to contribute to a successful transition (defined as the consumer being able to function well at home).

FIGURE 11
ELEMENTS OF A SUCCESSFUL TRANSITION



Proposition 1: Confidence is affected by preparation and support.

Proposition 2: Confidence, preparation, and support contribute to a successful transition.

In the model it is hypothesized that support and preparation are important to functioning at home in two respects -- directly, and as factors influencing confidence.

The information that emerged in the section on to "Preparation for Returning Home" (Ch.4. IV. C.) is consistent with, but expands upon, information about system support that emerged from the data in "The Consumer's View of Coordination" (Ch. 4. III.). One example is that written instructions were identified as an important system support related to coordination. In the section on "Preparation for Returning Home", it becomes evident that written instructions are only one part of a multi-faceted process that consumers identified as helping to prepare them for an active role in health care in their home environment. Another example is the visit by the Home Care nurse while the consumer was still in hospital; this was the system support that emerged most often as important to coordination. Consumers were very appreciative that this visit took place without their needing to request it, since many consumers did not know that the service was available. This finding provides guidance about how to manage boundaries between sectors from the consumer's perspective--it is useful for health care providers to provide information for the consumer before the transition occurs. Other examples of providing information before a transition occurred includes consumers knowing what to expect after surgery and after discharge from hospital (See "Expectations" Ch 4. IV. C. 1.).

C. COORDINATION, THE CONSUMER, AND TRANSITION

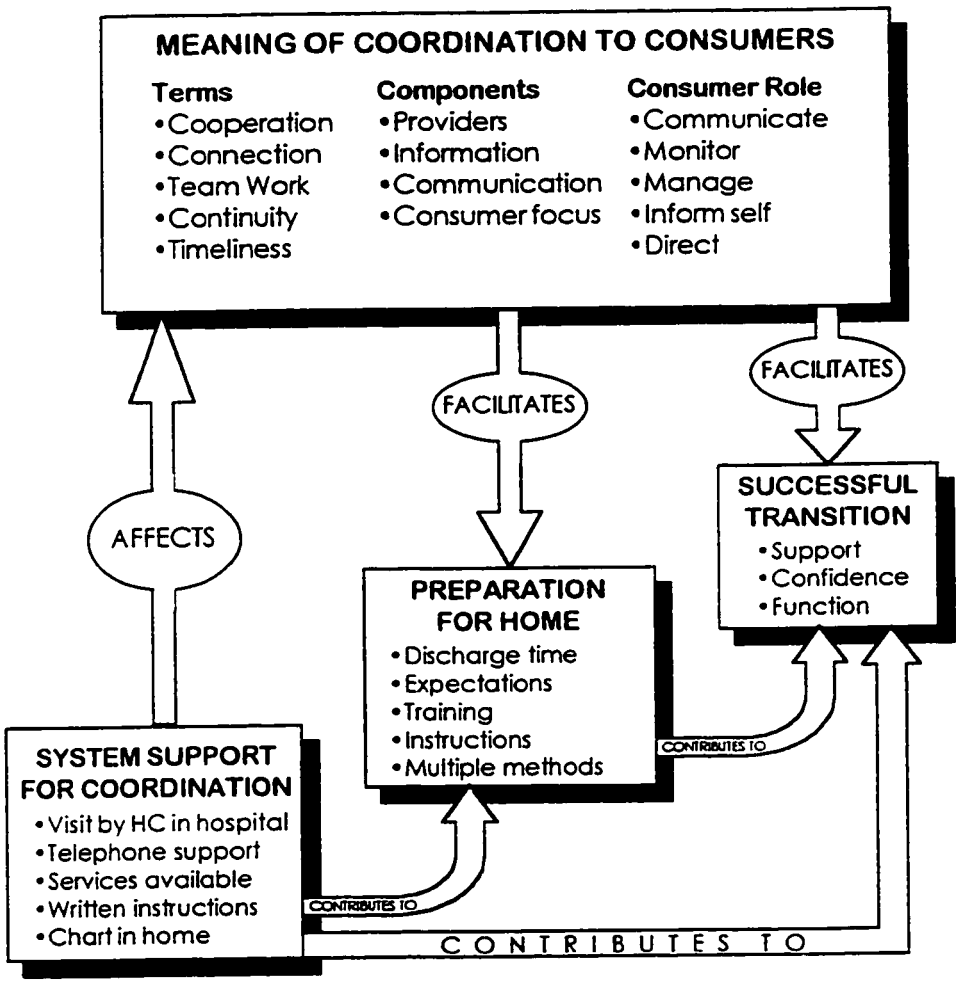
The findings about coordination, consumer preparation for returning home, health care services, and a successful transition experience were interrelated: a successful

transition occurred as the culmination of activities if all of the other elements were in place. Most consumers agreed with the timing of their discharge from hospital and described a positive, coordinated, successful transition experience which included preparation, support, and feeling confident about going home. Other consumers had an overall positive experience but identified a specific gap in services. One consumer refused to leave hospital initially, but once he and his spouse were "ready" he reported a coordinated, positive experience. However, a consumer who reported a negative experience illustrates the reverse, negative spiral of events that can occur. For this consumer, a premature (in her view) discharge from hospital, coupled with an absence of support at home, led to a lack of confidence, and the final result was she was not able to function in her home.

Figure 12 is a model containing propositions about the hypothesised relationships among the findings. The first part of the model describes WHAT coordination means to consumers which is presented as terms, components and the consumer role in coordination. Next the model identifies WHY coordination is important. It is proposed that coordination is related to a successful transition for the consumer from the hospital to home in two ways: 1) directly by facilitating a successful transition and 2) indirectly by facilitating preparation for the consumer to return home. Another aspect of the model identifies WHICH elements of the health care system affect coordination by facilitating preparation for returning home and a successful transition.

III. THE MODEL

FIGURE 12
COORDINATION, THE CONSUMER, AND TRANSITION



LEGEND

The meaning of coordination to consumers includes terms, components, and an important role for consumers in coordinating their own care.

Proposition 1 - Coordination facilitates

A) consumer preparation for returning home and

B) a successful transition experience.

Proposition 2 - System support

A) affects the meaning of coordination to consumers

B) contributes to preparation for returning home and

C) contributes to a successful transition between hospital and home.

IV. THE CONSUMER ROLE

The most dramatic finding from the study was the central role that consumers played in coordinating their own care. This theme emerged initially as one of the components of coordination--consumer involvement. It was such a dominant theme that five actions that consumers carried out relating to coordination were identified: communicate, monitor, manage, inform self, and direct. This finding has important implications for the role of the consumer in an integrated health services delivery system. In the following section, the literature on consumer involvement is explored as it relates to the findings in this study.

The organizational literature on service organizations is a particularly useful framework for interpreting the findings about consumer involvement in this study. Mills and Moberg (1982) identify a number of differences in processes and outcomes between organizations that manufacture goods and those that produce services. A major difference in service organizations, such as those that provide health services, is that the customer and the service provider must interact. An implication of this interaction is that, as well as providing the information that constitutes the "raw material" for the interaction, service organizations also often make use of clients' efforts in actually producing the service. For example, the customer fills out a deposit slip in the bank, or a patients carry their X-rays from one department to another in a hospital. However, consumers may have less knowledge than they require to carry

out the tasks they need to do. Thus they may need to be co-opted, or drawn into, organizational membership roles so they can acquire the necessary information and use it responsibly. This has implications for health care providers and managers. It means that in addition to providing clinical care, staff members need to serve as coaches for consumers to help them manage the boundaries between sectors. The findings on "Preparation for Returning Home"(Ch 4. IV. C.) provide specific examples of organizational activities, such as providing instructions in a variety of formats, that consumers found useful in supporting the consumer's role,

Baker and Pink (1995) emphasize the importance of the customer's perspective in obtaining a balanced picture of organizational performance and view the primary customers of health service organizations as patients and their families. They note that there are many challenges to obtaining information about the patient's perspective, including using appropriate instruments, interpreting the feed back, and actually applying the information obtained. Despite these difficulties, the authors observe that many health care organizations recognize that meeting the needs and expectations of patients is crucial to ensuring long-term support for the organization. Baker and Pink (1995) suggest that patients' concerns tend to fall into five main categories: time (prompt service), process quality (freedom from error), service (comfort and respect), outcome (alleviation of the clinical problem), and cost (minimize expense for the family). The findings from this study suggest that in

addition to asking consumers about the quality of clinical processes, as part of "process quality", they should also be asked about organizational processes. In particular, those processes that relate to the boundaries between sectors, which is a potential problem in a vertically integrated health services system.

In the approach of Shortell et al. (1995), the role of the consumer is taken a step further. In a Community Health Care Management System, health care organizations recognize people as citizens equipped to help provide for their own health care, rather than as clients who have no control. Shortell quotes a working paper from the Henry Ford system which observes that one of the duties that a health care system has is to "treat individuals effectively, economically, and with coordination and customer orientation when it is needed." This quotation recognizes that to become active participants, consumers have to acquire the knowledge, skills, and interest that will enable them to perform as effective, although temporary, members of service organizations (Mills 1986).

In Chapter 2-Background, in the section relating to coordination (V. E.) a number of mechanisms for achieving coordination were reviewed. Alter and Hage (1993) argue that the difficulties in predicting treatment or service outcomes in human services, make it difficult to standardize interventions and processes, which is one coordination mechanism. In this study, those consumers who expressed dissatisfaction with

coordination and the processes of care, indicated a major problem was that the providers had not recognized their unique needs. This finding supports Alter and Hage's (1993) view that standardizing activities has limited application for achieving coordination in a service industry such as health care. Since it is difficult to coordinate activities by standardized processes, consumers need to be involved in tailoring the activities to meet their own needs. This emphasizes the important role of the consumer and the need to include the consumer as a true and valued partner in the activities of care. Thus, the consumer becomes an integral part of the organizational system, central to integration, enabling, or assisting the production of services and the level of quality desired by the consumer (Mills and Moberg 1982).

Patient satisfaction with clinical care is increasingly considered as an outcome in its own right (Harrigan 1992) and it is now a focal concern of quality assurance and an expected outcome of care (Ford et al. 1997). However, the present study has found that in addition to assessing the outcomes of care, consumers can and should be involved in the processes of delivering that care, particularly in a vertically integrated system where coordination between sectors is a goal of the system. Patients and their families are eyewitnesses to the process of health care delivery (Gerteis et al., 1993). Since consumers are the stakeholders who experience the entire episode of an illness, they are ideally positioned to participate in, and to evaluate, the continuum of care. Active consumer involvement (as participants involved in coordinating their own

care) is one mechanism to accomplish the boundary spanning between organizational sectors that is required to achieve an integrated system.

V. ASSESSING COORDINATION

Grusky & Tierney (1989) evaluated the effectiveness of eight community support program mental health delivery systems by collecting data from service organization directors, case managers, chronically mentally ill clients, and family members. One of the four measures of effectiveness that were used in that study was a six-item scale for assessing services coordination (see Appendix I. C.). Coordination was measured using respondents' perceptions of the service system by asking respondents to indicate the extent to which they agreed with each of six statements that refer to aspects of the county's service system bearing on coordination.

The Grusky and Tierny coordination scale asks clients about coordination, but the questions are administrative, relating to programs and agencies. There is no information available on whether the items used in the coordination scale were meaningful measures of coordination from the client's perspective. In contrast, the present study explicitly identifies terms and themes that consumers identified as important to coordination. In addition, the findings about coordination were validated by a sample of the consumers in the present study. Therefore, an instrument

developed from the present work could be used to evaluate coordination in ways that are meaningful to the consumer.

The majority of consumers who were interviewed agreed that Alter and Hage's (1993) categories of access, comprehensiveness, and compatibility were related to, and important to, coordination. There were several instances, however, in which consumers did not know if these categories were related to coordination, or indicated that they believed these categories were NOT related to coordination. In responding to these categories, consumers often referred back to their own definitions of coordination providing further internal validation for the construct of coordination that emerged in the previous sections. These responses highlight the need to know something about the consumer's own definition of coordination in order to interpret their responses to the Alter and Hage categories.

Since a number of consumers did not agree that coordination was related to these categories, care needs to be taken in trying to assess coordination from the consumer's perspective. If, for example, a consumer indicated that there was not congruence between providers at different sites, it does not necessarily mean they felt there was a problem with coordination. It would depend on whether that consumer believed a "fit" between services or providers was related to coordination. Thus the consumer needs to be asked at least two questions: 1) "Was there a fit between the

care you received in hospital and the care you received at home?"; and 2) "Is this related to coordination?".

VI. CLINICAL INTEGRATION

In Chapter 2 (Background), a distinction was drawn between coordination and integration - the focus of coordination was the consumer and the focus of integration was the organization. During the course of the study, consumers were asked about their transition experiences and about coordination. Thus, the results capture the consumer's view of the consumer-related construct of coordination.

An analogy to distinguish between coordination and integration is the use of the terms "disease" and "illness". "Disease" is the medical description of a physiological event in a person's life. "Illness" is the person's experience of that event. The terms "disease" and "illness" relate to the same physiological process, but the terminology identifies the perspective. In this study "coordination" is derived from the consumer's perspective. However, it can also inform the organizational perspective of clinical integration, which is defined as the extent to which patient care services are coordinated across various functions, activities, and operating units of a system (Devers et al. 1994).

A. ASSESSING CLINICAL INTEGRATION

The study of Devers et al. (1994) outlined six dimensions for examining clinical integration (see Clinical Integration in Background Chapter 2). The present study provides data that elaborates on these criteria. For example, the present study provides information that identifies WHICH clinical support services are important from the perspective of the consumer (e.g. a visit by the home care coordinator while the consumer is still in hospital), rather than just counting the number of clinical support services that are shared. The present work also informs the question of HOW to develop shared clinical service lines (rather than counting the number of shared service lines). For example, providing information to consumers ahead of time, in a variety of formats and identifying common problems ahead of time.

The present study extends the approach of Devers et al. (1994) to assessing clinical integration in three important respects. 1) Although Devers et al. define clinical integration as the extent to which patient care services are coordinated, their study merely counts the number of shared protocols as a measure or proxy of this coordination. The present study explores the actual CONSTRUCT of coordination. 2) This study provides insight into the nature of interactions between operating units rather than merely counting the number of shared tools. 3) The Devers study assesses integration from an administrative perspective. The present study adds an understanding of coordination from the perspective of the consumer. Devers et al.

(1994) note that "further research is needed on the relationship between clinical integration and other dimensions of system performance such as patient satisfaction". The present study demonstrates that consumers views about coordination can actually help to evaluate clinical integration.

B. OVERCOMING BARRIERS TO CLINICAL INTEGRATION

Shortell and his colleagues view clinical integration as difficult, lifelong work, since it involves integrating across time, place, profession, and technology. Based on field work using quantitative methods, Shortell et al. (1996) identify four dimensions to understand the barriers to clinical integration. The present study supports and adds to the four aspects of the Shortell model.

1. Strategic--the need to focus on important issues.

Shortell et al. (1996) observe that one of the barriers to clinical integration is that most systems have not included a plan for clinical integration within an overall strategic plan. As systems become more integrated and begin to develop clinical integration plans as part of their overall strategic direction, the findings from the present study provide information that can be used as part of the clinical integration planning process. The most important strategic application of the present study, however, is to include consumers in planning for, and evaluating the coordination of services.

2. Structural--the overall organizational structure.

The present study identifies specific structural elements that consumers found useful, such as leaving patients' charts in their homes or a visit by the Home Care coordinator while they were in hospital. By including specific structural elements that consumers are concerned about, systems can enhance their clinical integration.

3. Cultural--underlying beliefs, values, and norms.

If consumers are to be partners in coordinating their own care in order to achieve clinical integration, the culture of the organization needs to value consumers and their input. The absence of a culture that values consumer input was evident in comments from a young blind woman who felt she was not able to make suggestions to the attending Emergency physician because *"he was not listening to me anyway so what was the point in trying to tell him*?".

4. Technical--those associated with the system have the necessary training and skills. Consumers in this study identified technical problems with coordination that would be barriers to clinical integration. For example, consumers identified a need to have trained personnel available at all system access sites to handle midline I.V. problems.

VII. HEALTH SYSTEM PERFORMANCE

A. SYSTEMS THINKING

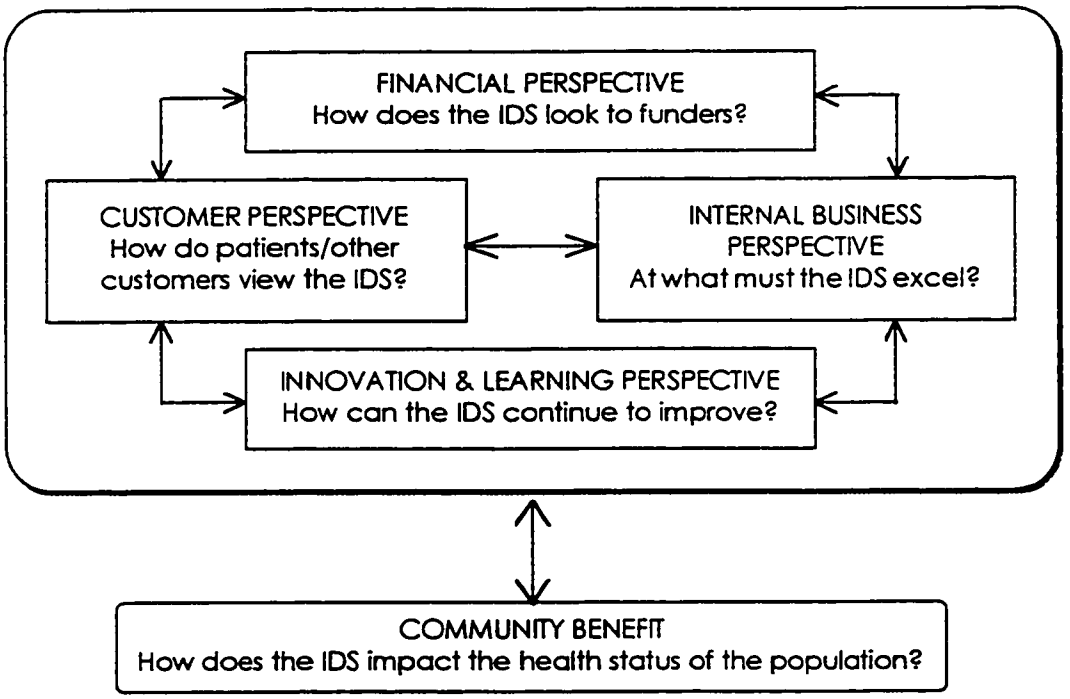
The notion of "wholeness" articulated by Bertalanffy (1968) in conceptualizing systems is extended by Senge et al. (1994) who encourage "systems thinking". Senge (1990) defines systems thinking as a conceptual framework with a body of knowledge and tools to help make the full pattern of interrelated actions and changes clearer. At its broadest level, systems thinking encompasses a large body of principles and methods oriented to the interrelatedness of forces and seeing them as part of a common process.

Evaluating health systems requires measures that emphasize interdependencies and common goals and that assess the contribution of the various operating units to the "system". The importance of evaluation goes beyond assessing performance since it is argued that the development, collection, and feedback of system-wide indicators can foster the development of "systems thinking" (Devers et al., 1994). The present study contributes to understanding an important element in any health system--coordination and provides a foundation of knowledge that will allow the assessment of coordination by an important stakeholder in the health care system--the consumer.

B. ASSESSING HEALTH SYSTEM PERFORMANCE

The framework proposed by Leggat and Leatt (1997) (see Figure 13) was introduced in Chapter 2 (see Figure 3) and is presented again here to facilitate the discussion about the changes in the framework that are suggested.

FIGURE 13
FRAMEWORK FOR MONITORING THE PERFORMANCE OF A STRATEGIC ALLIANCE
(from Leggat and Leatt 1997)

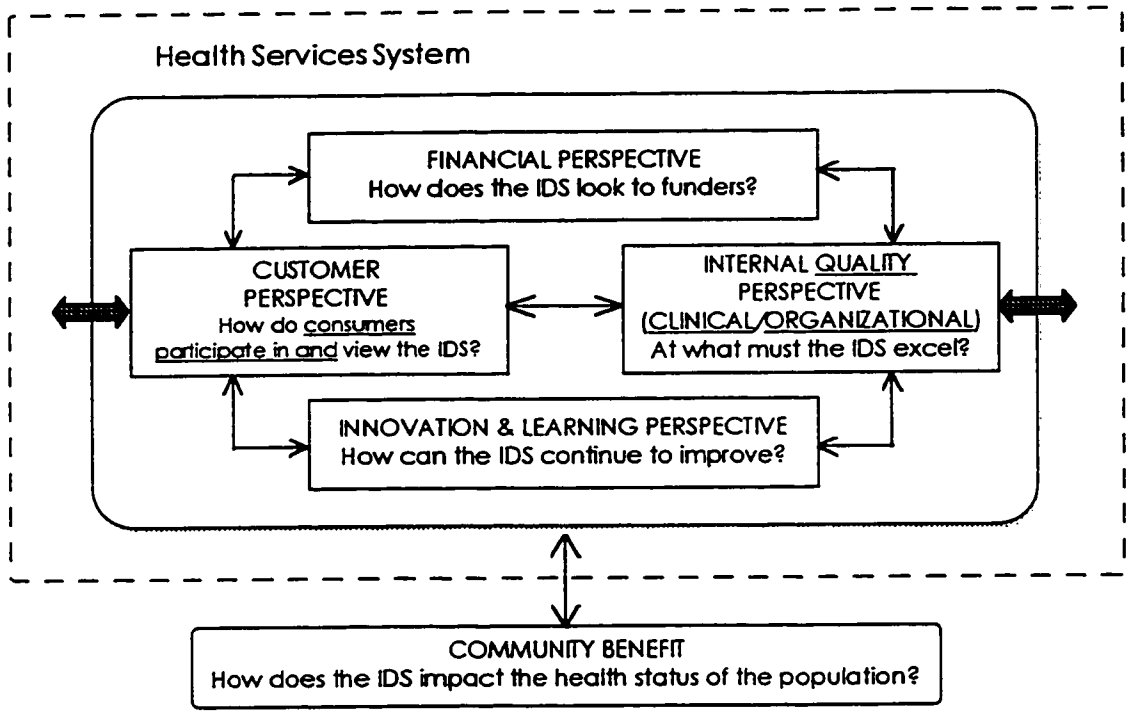


IDS = Integrated Delivery System

The findings from the present study suggest that the role of the consumer can be expanded from commenting on clinical aspects of care to commenting on, and participating in, organizational activities that relate to maintaining the system. The present study has identified consumers as key players in the task of coordination and provides a foundation for evaluating this organizational role. The findings from the present study lead to an extension of the Leggat & Leatt (1997) framework (see Figure 14). In addition to the existing arrows relating to the consumer's perspective, another arrow is added extending from the consumer to the system. The phrase "and participate in" is added to the description of the consumer's perspective which now reads "How do consumers view and participate in the IDS?" (IDS = integrated delivery system). Thus, in addition to consumer satisfaction with clinical care as one indicator of how well the system is working, the consumer should also be asked about the system itself regarding constructs such as coordination. In a similar manner, internal stakeholders could also be asked about system constructs.

A second revision to the Leggat & Leatt model (1997) is to change the "Internal Business Perspective" to "Internal Quality Perspective" with two dimensions: clinical quality (which would include, for example, clinical guidelines or protocols) and organizational quality (which relates to the organizational goals and processes). This change is suggested to help translate the model into a form that would be more easily recognized by those working in a health care system.

FIGURE 14
FRAMEWORK FOR MONITORING THE PERFORMANCE OF AN INTEGRATED HEALTH SERVICES DELIVERY SYSTEM
(Adapted from Leggat and Leatt 1997)

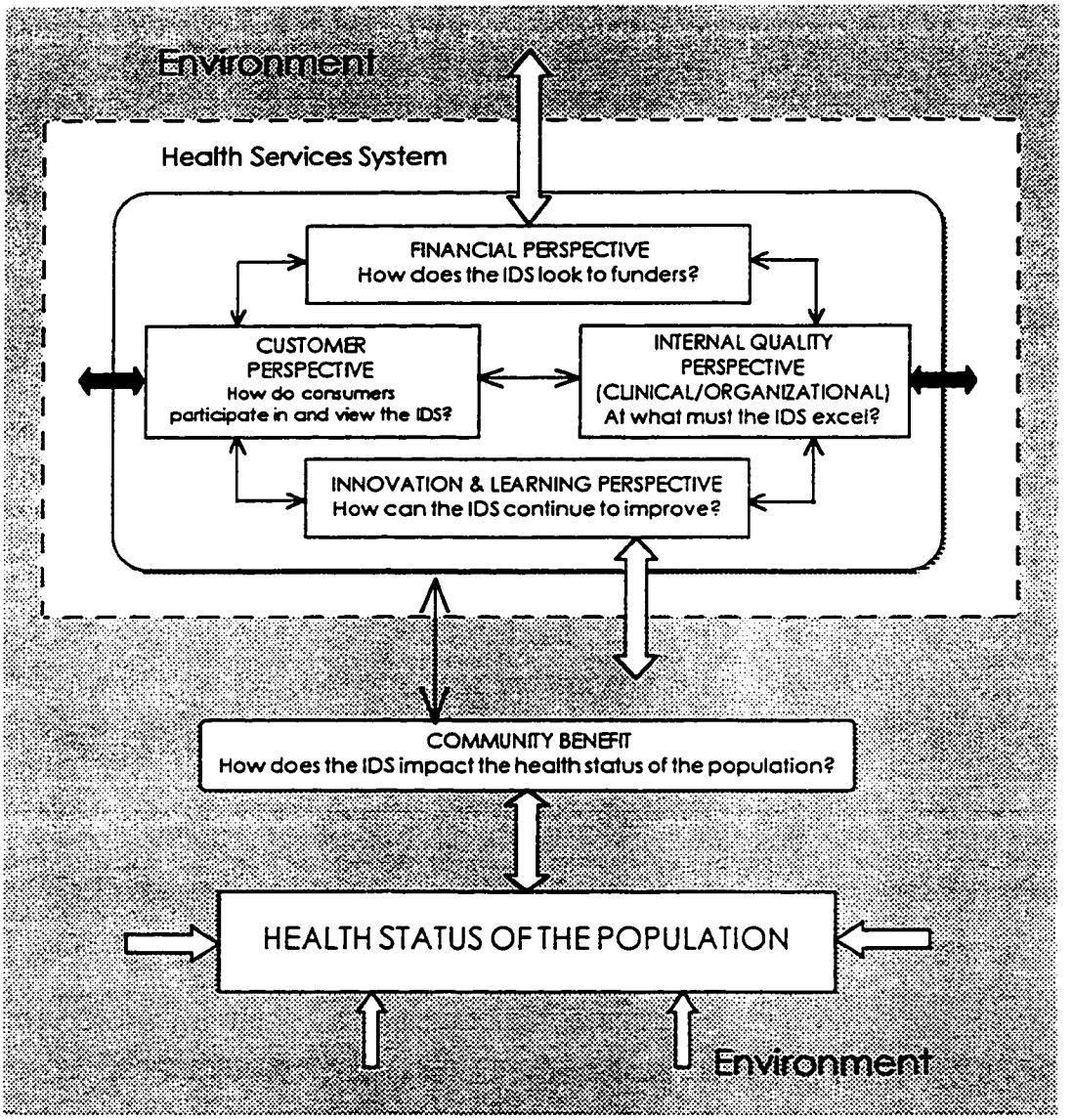


IDS = Integrated Delivery System

The last extension to the model is to include the external environment in the diagram (see Figure 14). Interactions with the environment are important considerations in an open system such as the health care system. The system-environment interactions are particularly important to the "financial perspective" and the "innovation and learning perspective". These two perspectives reflect the open systems approach which stresses connections to the environment. Two ways of assessing performance with an open system approach are: 1) the organization's success at obtaining resources (which may be physical, human, information, as well as financial as in the model) and 2) adaptation to the environment (the innovation and learning perspective). In the revised model there are arrows extending from these two perspectives into the environment.

The health care system is only one of the players in the organizational environment that affects the health of the population. The revised diagram includes arrows indicating that there are also other important factors that affect health, for example, the economic status of individuals and communities, and the interactions with other systems such as the educational system or the justice system. One of the future challenges for assessing health system performance will be to study the interface between the health care system and some of these other determinants that affect the health of the population. The findings from this study may have application in that broader task; that is, include the consumers of services in helping to manage the boundaries between the health care system and other systems with which it interacts.

FIGURE 15
FRAMEWORK FOR MONITORING THE PERFORMANCE OF AN INTEGRATED HEALTH CARE SYSTEM
(Adapted from Leggat and Leatt 1997)



IDS = Integrated Delivery System

VIII. THE STUDY

A. MAINTAINING RESEARCH QUALITY

Maintaining rigour in the research process is as important in qualitative research as it is in quantitative research, however, the manner in which quality is maintained differs between the two approaches. In this study the following categories are used to establish the "trustworthiness" (Krefting 1991) of the research: neutrality (Krefting 1991), dependability, credibility, and transferability (Miles and Huberman 1994). In the following section these four criteria are used as a framework to establish the quality of the research in this study. The qualitative categories, with the corresponding quantitative constructs, are defined and followed by a discussion of how each issue was addressed in this study.

1. Neutrality

ISSUE

Do the conclusions depend upon the subjects and conditions of the inquiry with "reasonable freedom" from researcher biases?

RESPONSE

(a) Using Text from Interviews to Support Conclusions

The findings are explicitly supported by examples from the data. Examples include short individual quotations to illustrate specific points, sections of interviews that are

representative of consumers' comments, and long segments of text that illustrate more than one point or a developing theme.

(b) Transcripts Reviewed by Peers

To determine whether the coding scheme that was emerging from the analysis of the interviews was appropriate, sections of interviews were reviewed by two groups of other researchers. Sections of the interview with Consumer 2 were reviewed by 20 researchers involved in the SEARCH program (an initiative to train Regional Health Authority researchers), and sections of the interview with Consumer 4 were reviewed with six students in an advanced research methods class. After individuals and groups had had an opportunity to review the transcript and decide upon codes, the researcher's coding scheme was presented to the group and there was extensive discussion about the codes and the emerging relationships among the categories.

In addition, two researchers experienced in qualitative research each coded a complete interview; one researcher coded the interview with Consumer 8 and the other coded the interview with Consumer 22. The interviews and the codes that were used were then discussed. Table 5 provides a few examples of sections of text that were coded, listing the codes used by the researcher and those used by the external reviewer.

TABLE 5
COMPARISON OF CODING

CONSUMER 8 (Male, 76 Years)		
TEXT	**RESEARCHER**	**REVIEWER**
215	Transition/Timing	discharge/timing
235	Coordination/Consumer Role	responsibility
260	Coordination/Consumer Role	Responsibility/ Decision Making
282	Transition/Experience/Coordinate	Transition/coordination/communicate
349	Coordination/Define/Communication	Coordination/Communication
385	Coordination/Communication	Communication/provider
430	Transition/Experience/Positive	Transition
437	Transition/Timing	Transition/Timing
CONSUMER 22 (Male, 51 Years)		
TEXT	**RESEARCHER**	**REVIEWER**
79	Transition/Experience/Positive	Access, Back up
96	Transition/Prefer/Site	Client Preference
121	Transition/Manage/Support	Support
168	Transition/Manage/Confidence	Confidence
195	Coordination/Define/Communication	Communication

There were some minor differences in the vocabulary chosen but there was a great deal of agreement about the underlying constructs. In many instances differences in coding were due to the researcher using codes which were part of an index system that incorporated information from other interviews. Therefore, the researchers codes also reflected the developing theory. For example for Consumer 22 the reviewer

coded the line of text 195 as communication. The researcher also coded this text as communication but in addition, the text was coded to reflect that communication was related to a definition (code word define) of coordination (code word coordination).

One reviewer questioned if some of the questions used by the researcher were somewhat leading. This could have been related to two factors. First, the reviewer did not have the interview guide when she was reviewing the interview. Secondly, there were two types of questions that were asked: a) unstructured questions about the meaning of coordination to consumers; and b) more specific questions to probe aspects of the transition experience that were emerging as important in preceding interviews (See Methods - Chapter 3. Section IV. B.). In subsequent interviews the researcher was particularly careful to use prompts that were as neutral as possible.

(c) Review by "Content Experts"

Early in the data collection and coding process, the preliminary categories were discussed with a group of 22 Home Care coordinators and managers that work closely with the consumer group. The coordinators agreed with the categories that were emerging and suggested an additional question to explore, which was "Do consumers find that receiving care at home rather than in hospital causes a financial burden?".

(d) Retain the Transcripts

The transcripts of the tapes (without personal identifiers) have been retained for possible re-analysis.

2. Dependability (Auditability/Reliability)

ISSUE

Is the process of the study consistent and reasonably stable over time and across researchers?

RESPONSE

(a) Interview Guide

An interview guide was used (see Appendix II. A. 5.). Although the guide evolved somewhat during the course of the study, it provided a consistent foundation for the interviews.

(b) One Interviewer

All interviews were conducted personally by the researcher to eliminate the variability related to different interviewers. This approach has it own limitations since it is susceptible to bias by the researcher. This was dealt with by having peers review the interviews and transcripts (see point b under Confirmability).

(c) Review of Transcripts by Peers--see point b under Confirmability

3. Credibility (Internal Validity)

ISSUE

Do the findings of the study present an authentic portrait of what was being studied?

RESPONSE

(a) Review by Participants

The one-page summary of the consumer's view of coordination and a covering letter (see Appendix II. C. 1. and 2.) were mailed to a purposive sample of participants who had been interviewed in the study (see Methods). Each subject was contacted by telephone and asked about each section in the summary.

All of the participants who were interviewed were pleased with the summary. They did not feel that anything had been left out or that anything in the summary was incorrect or misleading. One consumer expressed his support in the following way: *"It captured the things that were important about my experience and I can't think of anything to change about my care or the summary"*. Another consumer indicated that the summary was *"very good and very complete"*. One consumer expanded on a couple of the points in the summary. He agreed that the chart at home was useful for various health care providers but it was also useful for consumers and their families. He also pointed out that, although a phone number was useful, it needed to be a number that could be used outside regular office hours as well.

(b) Internal Coherence

i) There was convergence in the descriptions of coordination from consumers with different experiences. For example, communication between health care providers was identified as an important component of coordination by both consumers who had a positive experience (*"The communication is fantastic"*) and consumers who had problems (*"It was just a lack of communication"*).

ii) As well as consistency between subjects, there was also consistency within each interview. For example, Consumer 4 identified information or knowledge as an important aspect of coordination. She defined coordination as *"everybody knowing what's going on in a situation"*. She had difficulty getting help for a problem with her midline I.V. which she described in terms of a lack of information.

> *"I ended up having to go to the Emergency and the Emergency doctors had no clue as to what they were supposed to do with me."*

Her suggestion for a solution was:

> *"I think the service itself was good (Home I.V.) but to train more people in the knowledge of what's going on."*

The consistency of a single consumer's views about coordination was also evident in the follow-up interviews about the coordination summary (see Point (a) above, related to Credibility). Many of the consumers re-emphasised the aspects of coordination that they had described during their original interview.

CONSUMER 22--Follow-up interview
[His original coordination definition included communication.]

Home care was well informed, there was good communication, they helped me learn what I had to do, allowed me to be independent but with the back up if I needed any help.

There was also internal consistency between the original descriptions about coordination that emerged in response to open-ended question asking consumers what coordination meant to them and their subsequent comments about the transition experience, as well as their responses to the coordination literature. For example, for one consumer *"continuity"* was part of his original definition of coordination. He found his transition experience was positive and that the care had been coordinated because there was continuity. He also indicated that the category from the literature of 'Comprehensiveness' was important to coordination *"because if it's not complete then...it can't be continuous"*.

4. Comment

The three categories of neutrality, dependability, and credibility are interrelated. The consistency in coding between different researchers reviewing different interviews that were conducted at different times supports both confirmability and dependability. The consistency that was evident within individual interviews, between subsequent interviews with the same person, and among interviews with different consumers, supports both dependability and credibility.

5. Transferability (External Validity/Generalizability)

ISSUE

How far can the conclusions be "generalized"?

RESPONSE

This study included 33 interviews (a relatively large number for a qualitative study) with consumers who were comparable to the sampling frame (see Chapter 4-Section II. "Participants"). The findings were validated by participants. Therefore it is reasonable to generalize the descriptions of coordination and information about the consumer's role in coordination to a fairly specific group of consumers - those who can be interviewed, are referred from the four acute care hospitals in Calgary, and who received short-term Home Care services from the CRHA.

The framework developed in this study about the specific aspects of coordination that are important to consumers and the part that coordination plays in a successful transition between hospital and home would need to be validated in other regions to determine if the findings are generalizable to short-term Home Care clients outside Calgary. In addition, the findings may not be generalizable to other groups of Home Care clients in Calgary. Short-term clients may be different from other Home Care clients in a number of ways. Long-Term Home Care clients may be older, with a higher proportion of women and a different mix of diagnostic categories than those of the short-term Home Care clients. Home Care Palliative clients are also likely to

have different demographic characteristics and diagnoses, with different needs for system support.

Considerable detail has been included about the participants and the analysis to allow other researchers to determine how generalizable this study is to their own research (Miles and Huberman 1994).

B. LIMITATIONS

The lack of generalizability of qualitative research is often regarded as a limitation of the design (Marshall and Rossman 1989, Creswell 1994). To mitigate this problem, in the present study the participants who were interviewed were compared with the consumer group that they were drawn from, that is, short-term Home Care clients referred from a Calgary hospital. The participants reflected the composition of the eligible population according to sex and age (see Chapter 4 Findings - Section II. Participants). Therefore, the findings about what coordination means to consumers, the role of the consumer, and coordination in a successful transition between hospital and home, appear to be applicable for this group of consumers, if they can be interviewed.

A limitation of the study was that the consumer needed to be able to be interviewed in order to be included. This limits the applicability of the study for those who can not

speak English and those who are cognitively impaired. There was evidence of sampling bias in the study. In the group that was not interviewed, there were four consumers with a diagnostic category indicating a nervous system or mental disorder and four consumers who could not be interviewed due to limited English speaking ability. Therefore the findings from this study should not be applied to consumers with mental disorders or who do not speak English unless there is further work to validate the findings from this study with those consumers.

Another potential limitation with qualitative research is researcher bias. The steps taken to minimize this problem are discussed in the section on "Maintaining Research Quality--Confirmability". These include using words or sections from the interviews to support the conclusions drawn, having the interviews and coding scheme reviewed by other qualitative researchers and content experts, and having a summary of the findings about coordination validated by a sample of the participants.

The limitations identified above still apply to this study, despite the steps taken to reduce their effects.

C. STRENGTHS AND APPLICATION

A strength of the present study is that it provides a valid picture of what coordination means to the particular group of consumers who were interviewed--those receiving

short-term Home Care services in the CRHA. The findings were very robust. There was both internal consistency (consumers came back to the same ideas about coordination in different parts of the interview) and consistency between different consumers. (See Maintaining Research Quality Chapter 5, Section VIII. A.)

The finding that consumers play an important organizational role links to the literature on service organizations (Mills and Moberg 1982, Mills 1986). This organizational role for consumers may be applicable in a variety of settings; however, just as the effective application of clinical practice guidelines requires a local implementation strategy (Harrigan 1992), so will appropriate ways of including consumers in organizational roles need to be examined in the specific context in which their involvement is sought.

A major contribution of the present study is the demonstration that consumers can and should be consulted about organizational constructs. The present study provides a foundation for developing an instrument to assess coordination, one aspect of the performance of an integrated health service delivery system, from the perspective of a key stakeholder--the consumer of health services. This study also provides specific information about how to manage the boundaries between sectors as well as general guidance about the importance of including consumers in this organizational process.

CHAPTER 6: CONCLUSION

I. IMPLICATIONS FOR PRACTICE

The findings identify terms and components of coordination, and aspects of a successful transition experience, that consumers in this study viewed as important. In addition, five activities that consumers undertake as key players in the organizational task of coordination emerged. A preliminary theory about the interrelationships between aspects in the findings was developed.

As is customary, comments and suggestions are presented based on the research that has been conducted. Although care has been taken to present an authentic expression of the views of the group of consumers who participated in the study, this is an exploratory, qualitative study and the generalizability of the findings is limited (see Limitations, Chapter 5 - VII. B.). Therefore, the implications for practice should be considered as preliminary and viewed cautiously until the findings and theories are validated with further research.

A. ORGANIZATIONAL ROLE OF CONSUMERS

The most dramatic finding in the study was the central role that consumers play in

coordinating their own care. A role is a set of expectations about what one should do (Heiss, 1981). Since roles are social (Stryker and Statham, 1985), an interaction is implied. One position needs to be referenced to others to be meaningful; for example, "teacher" implies "learners"; "employees" implies "employer". Thus, an organizational role for consumers also has implications for health care providers and health care managers, which are discussed below.

1. Consumer Involvement in Organizational Processes

The present study demonstrated that consumers are involved in coordinating their own care, yet there is not an explicit recognition of their role in this process. The consumers in this study identified aspects of coordination that are important to them and this information could be used to include consumers in facilitating and evaluating organizational processes in health care.

SUGGESTION: Consumers should be recognized as partners in the processes related to providing care. As part of the assessment of the performance of a health system, consumer input should be sought about organizational processes, in addition to their assessments about clinical care.

2. Consumer Involvement in the Timing of Discharge

All consumers, except for one, preferred to be at home. Since most consumers are anxious to leave hospital, and they play an important role in coordinating their own

care, it is important that consumers' views about the timing of their discharge from hospital be considered.

SUGGESTION: Consumers' views about the timing of discharge from hospital should be included as part of the discharge planning process.

The two consumers who felt they were discharged too early from hospital were non-Caucasians. Although these people were satisfied with most aspects of their care, their discomfort about the timing of discharge raises questions about the need for additional system support for people whose first language is not English or who are from different cultural backgrounds. Both information and communication were identified in the study as important components of coordination. It may be that people from different cultures have different expectations about the health care system and may require more information and additional communication to help them manage the transition from hospital to home.

SUGGESTION: Consumers from ethnic backgrounds who have additional information or communication needs related to their language or culture may require additional explanations about the discharge process or additional health care system support.

3. Health Care Providers

To enable consumers to participate as partners in their organizational role, it is vital

that health care providers are aware of this role for consumers. In addition, for consumers to participate effectively as partners, they need support from providers. This adds to the role of the provider since, in addition to providing clinical care, providers also need to serve as coaches or teachers for consumers. For example, to manage the transition home, consumers found it useful to receive instructions more than once in a variety of formats: verbal instructions, hands-on training, and written instructions with advice about common problems that might be encountered.

SUGGESTION: Health care providers need to be aware of the important role that consumers play in coordinating their own care and consider ways to assist consumers in carrying out this role.

4. Health Care Managers

Kaluzny and Shortell (1994) predict a major change from managing an organization to managing a network of services or a continuum of care. Managing boundaries between organizations, or sectors within an organization, and managing the transition process across these boundaries for those who use the system are critical for developing an integrated system. One mechanism to help manage boundaries is to draw on the consumer as a temporary organizational member.

SUGGESTION: In planning and evaluating health system performance, managers should solicit consumers' views about organizational processes, particularly those that cross boundaries,. Managers also need to foster an organizational culture that values

and respects consumer input.

B. ASSESSING COORDINATION

A number of consumers did not agree that coordination was related to the categories identified by Alter and Hage(1993)--access, comprehensiveness, or compatibility. This finding demonstrates some of the challenges in assessing coordination from the consumer's perspective. For example, in order to use congruence between health care providers in hospital and at home as a measure of coordination, one would first need to determine if the consumer believed that this congruence was related to coordination. Some consumers in this study indicated that what went on in hospital and what when on at home were very different and, therefore, congruence between the two did not reflect coordination. A negative answer may mean that there was not coordination or it may mean that there was not congruence, but that this lack of congruence was not related to coordination. Consumers may believe their health services were coordinated even if there was not congruence between providers.

SUGGESTION: Any measures that are used to assess coordination from the consumer's perspective need to include questions to validate the measure with the consumer group. For example "Was there a fit between the care that you received in hospital and the care you received at home? Is this related to coordination?"

II. RECOMMENDATIONS FOR FUTURE RESEARCH

The meaning of coordination was identified by the consumers who were interviewed as specific terms, multi-faceted components and a significant role for consumers in coordinating their own care. This view of coordination was validated by a sample of consumers who were interviewed.

There was evidence from this study that supported a number of propositions about the elements of a successful transition from hospital to home and the relationships between coordination, a successful transition experience and health care system support. These propositions were not tested in this study and lead to the following hypotheses, which need to be tested with a similar group of consumers as well as different groups of consumers.

I. Hypotheses relating to a successful transition experience

Hypothesis I. A. - Consumer confidence is affected by preparation and health care system support.

Hypothesis I. B. - Consumer confidence and health care system support contribute to a successful transition.

II. Hypotheses relating to the role of coordination

Hypothesis II. A. - Coordination facilitates consumer preparation for returning home.

Hypothesis II. B. - Coordination facilitates a successful transition experience.

III. Hypotheses relating to health care system support

Hypothesis III. A. - Support from the health care system affects the meaning of coordination to consumers.

Hypothesis III. B - Support from the health care system contributes to preparation for returning home.

Hypothesis III. C - Health care system support contributes to a successful transition between hospital and home.

This study provides a foundation of information about what consumers mean by coordination, what is important to them in preparing to return home, and what health care system support is important. Therefore, it is possible to now test these hypotheses.

The present study is only a first step of a research journey. These findings need to be investigated with other groups and validated or modified as needed. The consumers in this study had been referred from an acute care hospital for short-term Home Care services. Other groups whose views should be investigated include:

1) a similar population in other Health Regions;

2) different populations in Calgary, for example consumers referred from hospital who are receiving long-term Home Care;

3) groups of consumers who were excluded from this study, such as those who were

not interviewed because of language difficulties or mental health problems; and 4) family members.

In addition to (or in conjunction with) testing and refining the model, an instrument based on the model needs to be developed to assess if coordination from the perspective of the consumer has actually occurred. The development of an instrument is an important research activity in its own right, involving developing questions that are clear and appropriate, pretesting, and establishing the validity and reliability of the instrument.

An instrument could contribute to a concatenated (Stebbins, 1992) research agenda such as tracking findings over time. A research agenda allows more complex questions to be investigated. For example, are there changes in responses about coordination when there is more stability in a system compared with the present study which occurred in the middle of rapid and significant organizational restructuring.

The investigation of other study populations also allows for comparisons such as the following examples. Do consumers receiving long-term care seem to have the same active role in coordination that consumers in short-term care identified? Is the health care system support required by consumers receiving palliative care different from the health care system support identified by short-term Home Care consumers?

Another avenue of investigation would be to examine consumers' roles in managing other boundaries or transition experiences. For example, consumers could be valuable participants in managing the boundaries between the health care system and other systems that relate to health, such as the social welfare system.

A further extension of this work would be to investigate how other stakeholders, such as health care providers and managers, view coordination and integration. This would involve a series of steps similar to those identified above--a preliminary investigation about the construct with the target group, followed by validation of the findings, and the development of an instrument to assess if coordination were in fact occurring.

The next question to investigate would be how does an attribute related to the system itself, such as coordination, affect overall system performance, and how does it relate to other measures of health care system performance, for example, consumer satisfaction or health related outcomes.

Another line of inquiry would be to explore other organizational roles of consumers and how the health care system can support these roles. At present, the roles of consumers of health services identified in the literature are limited to patient satisfaction questionnaires (Baker et al., 1995, Ford at al., 1997), and involvement on the boards of health care organizations (Ahearn et al 1997, Lomas et al. 1997).

The present study finds that consumers also have an important organizational role to play in the coordination of their own care. It would be worthwhile to investigate what other organizational roles consumers can or do play.

III. SIGNIFICANCE

Despite the prominence of coordination in the organizational literature and the health services literature, there is little empirical work on coordination (Alter and Hage 1993, Grusky and Tierney 1994) and no empirical studies about what coordination means to consumers. This is the first study that has actually identified what coordination means to consumers and what aspects of health care system support consumers find important for coordination and for helping them prepare to return to their home. It is also the first study to identify the elements that contribute to a successful transition. In addition, the study has produced a model (the only model), grounded in data from interviews with consumers, which proposes how coordination contributes to a successful transition.

This work provides a foundation of information about coordination, preparation for returning home, health care system support and the successful transition experience that has allowed hypotheses to be developed, that can now be tested by further research. It also provides a foundation of information which can be used to assess if

coordination has actually occurred. Although coordination is identified as an anticipated outcome of the restructuring of health services, until now there has been no foundation of information that could be used to evaluate if coordination has occurred.

In assessing system performance, the emphasis needs to be on actual SYSTEM attributes. "It is important to recognize that system performance at any given level may not be analyzable as a simple aggregation of system performance at lower levels. This is one of the principal features of any system, its performance is determined as much, if not more, by the arrangement of its parts--their relations and interactions--as by the performance of the individual components" (Flood 1994 p. 323). Another major contribution of the present study is the demonstration that consumers can and should be consulted about organizational constructs. The consumers' views about coordination that emerged from this study contribute to an understanding of an actual attribute of the system itself, that is, coordination, in contrast to examining the outcome of what the system produces. This particular attribute, coordination, is especially important in managing boundaries across sectors, in a vertically integrated health services delivery system, which is what the health care regions in Alberta are striving to become. This study provides specific information about how to manage the boundaries between sectors as well as general guidance about the importance of including consumers in this organizational process.

Managing the boundaries between organizations, or sectors, within a system, and managing the transition process across these boundaries for those who use the system, are critical for developing an integrated system. A major finding that emerged from this study was the crucial role that consumers play in spanning intra-organizational boundaries by participating in the coordination of their own care.

The present work contributes to understanding, and provides a foundation for evaluating, a critical aspect of vertical integration in a regional system: the coordination of services between acute care and Home Care. Health regions in Alberta, and in other parts of Canada, face the challenge of managing transitions between sectors that provide services at different stages of the continuum of care. Most other industrialized countries are dealing with similar issues brought on by earlier discharges from acute care hospitals and the need to provide care in the community (WHO 1996). Therefore, knowledge about coordinating health services across sectors in an integrated delivery system is relevant internationally, as well nationally and regionally.

A major result from the present study--the role of the consumer in coordinating care--was unanticipated. This finding emphasizes the importance of a qualitative approach as a first step in investigating previously unstudied phenomena in their social context. In addition, the variations in the findings when consumers were asked about the

coordination categories in the literature highlight the need to understand the construct that is being investigated, from the perspective of the stakeholder whose views are sought. In this study, the theory about the organizational role of consumers, and the actions that they take as part of that role, are firmly grounded in the data from the interviews.

Coordination has been identified as an important anticipated outcome of the fundamental reorganization of our health system (Alberta Health, 1994). The present study is a first and unique step of a research agenda to assess if the new regional structure for the delivery of health services actually does provide coordinated service for consumers and how this relates to health system performance.

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LIST OF APPENDICES

APPENDIX I.A.

CLINICAL INTERGATION MEASURES
(From Devers et al., 1994 p. 16)

DESCRIPTIVE SUMMARY OF CLINICAL INTEGRATION MEASURES			
Concept/Measure	**Mean**	**Standard Deviation**	**Range**
Clinical Protocol Development			
Number of protocols per operating unit (OU)	2.9	4.9	0.0-16.0
Percent of protocols shared with at least one other OU	61.5	31.7	25.0-100.0
Medical Records Uniformity and Accessibility			
Percent of medical records features shared	10.9	15.2	0.0-48.2
Availability of medical records information	2.3	0.8	1.0-3.0
Percent ID features shared	11.4	17.8	0.0-44.4
Percent of OUs with electronic access to at least one other OU	9.5	17.3	0.0-42.9
Percent OUs using an integrated record with a problem-oriented flow sheet	5.0	16.6	0.0-55.0
Clinical Outcomes Data Collection and Utilization			
Percent of 15 clinical outcomes collected and shared	16.3	28.4	0.0-81.8
Average number of 15 clinical outcomes collected and shared	1.9	3.3	0.0-9.3
Clinical Programming and Planning Efforts			
Percent of 6 programs used by OUs	34.6	25.9	0.0-86.4
Percent of OUs sharing a PHO	12.8	29.4	0.0-100.0
Percent of OUs sharing a recruitment plan	42.3	47.0	0.0-100.0
Average number of 6 programs used	2.1	1.6	0.0-4.9
Shared Clinical Support Services			
Percent of 9 support services shared by at least one other OU	17.6	17.3	0.0-49.4
Average number of 9 support services shared by at least one other OU	1.4	1.4	0.0-4.0
Shared Clinical Service Lines			
Percent of 10 clinical services shared with at least one other OU	15.2	19.8	0.0-61.1
Average number of 10 clinical service lines shared with at least one other OU	1.3	1.7	0.0-5.0

APPENDIX I. B.

MEASURES FOR EVALUATING THE PERFORMANCE OF AN INTEGRATED HEALTH DELIVERY SYSTEM

(Adapted from Leggat and Leatt 1997)

Evaluating The Performance Of An Integrated Health Delivery System	
CUSTOMER PERSPECTIVE: How do patients and other customers view the IDS?	
POTENTIAL PERFORMANCE CRITERIA	POTENTIAL PERFORMANCE MEASURES
The IDS maintains or improves client satisfaction	- client satisfaction surveys
The IDS maintains or improves quality of care	- quality of care measures
	- client satisfaction surveys
The IDS improves client flow through services delivered	- client satisfaction surveys
	- transfers among services
	- time from referral to initiation of service
	- admissions for the IDS
	- outpatient attendance for the IDS
	- admittions for the organization(s)
	- outpatient attendance for the organization(s)
The IDS improves client outcomes	- client satisfaction surveys
	- mortality & morbidity statistics
	- functional status assessments
The defined level of clinical integration is achieved	- level of clinical protocol development
	- level of medical records accessibility
	- percent shared clinical outcome data
	- percent shared programmatic planning
	- percent shared clinical support services
	- percent shared clinical services
INNOVATION & LEARNING: How can the IDS continue to improve?	
POTENTIAL PERFORMANCE CRITERIA	POTENTIAL PERFORMANCE MEASURES
The IDS promotes increased industry legitimacy	- perceptions of legitimacy of key stakeholders
	- demonstrated impact on policy making process
	- reputation of alliance
The industry position is strengthened	- profile of industry
	- proportion of standardization within industry
	- level of trust among participants
The IDS can attract sufficient resources for research, development and innovation	- research grants
	- balance sheet
The IDS results in increased sharing of clinical knowledge and resources	- joint education initiatives
	- number of consults
	- critical mass requirements
The IDS results in a stronger position for the participating organizations	- competitive advantage
	- perceptions of legitimacy of key stakeholders
	- client satisfaction
	- staff satisfaction
	- reputation of organization(s)
The IDS improves organizational survival	- number of years in operation
The IDS encourages innovation in health care delivery	- new technologies or treatments introduced

FINANCIAL PERSPECTIVE: How does the IDS look to funders:	
POTENTIAL PERFORMANCE CRITERIA	POTENTIAL PERFORMANCE MEASURES
There is improved access to resources	- operating budget(s) - level of physician-system integration - fundraising - successful staff hires - medical staff recruitment - staff turnover - access to technology
The IDS increases the strength of the participants in financial negotiations	- negotiating process - operating budget(s)
The IDS results in decreased operating costs	- cost per episode of care - operating margins - transaction costs

INTERNAL BUSINESS: At what must the IDS excel?	
POTENTIAL PERFORMANCE CRITERIA	POTENTIAL PERFORMANCE MEASURES
The IDS maintains or strengthens the mission and values	- perceptions of key stakeholders
The IDS responds to regulation requirements	- percent of regulation requirements met
The goals of the IDS are met	- percent of IDS goals achieved
The IDS results in improved productivity in service delivery	- productivity measures
The related participant organizational goals are met	- percent of participant organizational goals achieved
The defined level of functional integration is achieved	- percent of functional items standardized
The participants in the IDS perceive the existence of acceptable norms of equity	- perceptions of reciprocity - perceptions of fair rates of exchange - perceptions of distributive justice
The IDS results in improved attraction, recruitment, retention, and motivation of staff	- measures of morale & job satisfaction - measures of organizational commitment - staff turnover

COMMUNITY PERSPECTIVE: How does the IDS impact the health status of the population?	
POTENTIAL PERFORMANCE CRITERIA	POTENTIAL PERFORMANCE MEASURES
The IDS meets community health needs	- community health status indicators - preventable morbidity & mortality - functional status indicators - immunization rates - poverty - housing - education levels - literacy
The IDS assists individuals to take responsibility for their health status	- education programs - community development - health promotion/prevention initiatives - community health status indicators
The IDS ensures sufficient community input	- membership of board and advisory committees - reputation in the community
Community health levels are maintained or improved with decreased costs	- health care costs per capita
IDS clients receive their care in the location most appropriate to their needs	- client satisfaction - alternative level of care days in hospital - utilization review measures - unscheduled hospital readmissions - wait lists for services
The IDS provides sufficient opportunities for education of health care professionals.	- number of health care students - consistency with human resources plans

APPENDIX I. C.

COORDINATION SCALE

by Grusky and Tierney

Response alternatives are: definitely the case; probably the case; probably not the case; definitely not the case; have no knowledge on this.

1. The agencies in this county that serve chronically mentally ill persons work very well together.
2. The political leadership in this county is very committed to programs to assist chronically mentally ill individuals.
3. One of the problems in this county is that agencies are constantly fighting with each other.
4. There are a lot of agencies that are supposed to assist chronically mentally ill clients; the problem is they all have conflicting rules and requirements.
5. Services for chronically mentally ill individuals are well-coordinated in this country.
6. Chronically mentally ill persons in this country are not getting the services they need because no agency takes the lead to see that things get done.

APPENDIX II. A. 1

24 JUNE, 1995

THE CONSUMER'S VIEW OF COORDINATION
AS A MEASURE OF HEALTH SYSTEM PERFORMANCE

Researcher - A. Harrison
Home Care Manager - B. Hannah

HOME CARE WORKFLOW PLAN

1. TEAMS

A. Teams 1 to 5

Each week (week 1) one team secretary will be designated to send out the contact letter about the Coordination Study to all Short Term Clients who have been referred to Home Care from a hospital. The letters will be sent out each day for one week. It is anticipated there will be about 10 to 15 letters per week. (40-60 clients per team per month = 10-15 new Short Term Clients per team per week).

B. Team 7

Since there are only about 10 new clients per month from the Rocky view area, letters will be sent to all eligible clients (referred from a hospital to Short Term Home Care) for an entire month. The secretary for team 7 will give a list to Jerry McAra each week of the clients that have been sent a letter.

2. SENDING LETTER

When she receives the client's name, the Team Secretary:

A. Registers the client in the Home Care Information System (HCIS).

B. At the same time generates an envelop and sends the letter to all Short Term Home Care Clients that have been referred to Home care from a hospital.

3. DAILY LIST

Each day the team secretary gives Jerry McAra a list of the clients that the letter has been sent to. The letter asks clients to call Jerry McAra within 2 days of receiving the letter if they do NOT want to be called by Alex Harrison.

4. WEEKLY LIST

On Monday of the following week (week 2) HCIS prints out a list of all Short Term Clients referred from a hospital to the identified team. The list will include: team number; date client was registered with home care; where the referral came from; clients Home Care Identification Number; clients name, address, telephone number, gender, age, diagnosis and diagnosis code.

5. LIST TO ALEX

On Thursday of week 2 (the week after the letters are mailed by the team secretary) Jerry McAra gives Alex Harrison a list with: the client's name, telephone number, source of referral and date of registration with Home Care. The clients who have called Jerry to say they do not want to be part of the study will have their names removed from the list that is given to Alex Harrison. Alex will telephone clients about the study in the order that they were registered with Home Care. If any clients call Jerry McAra to say they do not want to be part of the study after Jerry has given the list to Alex, Jerry will advise Alex by telephone.

6. CROSS CHECKING

The list from HCIS will be cross checked against the list that Jerry McAra is given each day to monitor if a letter is sent to all eligible clients. The list without names, telephone numbers and street addresses (with postal codes only) will also be used to generate a description of those clients who choose not to participate in the study. This will be used to determine if the subjects who are interviewed in the study are representative of the population of Short Term Home Care clients.

Calgary Health Services
Working together for a healthy tomorrow!

June 23, 1995

APPENDIX II. A. 2.
Letter to consumer

Dear Home Care Client,

I am writing to you about an important health care study that is being carried out in Calgary. There have been many changes relating to health care in the province of Alberta and in the Calgary Region. One of the reasons for making changes is to improve the coordination between various parts of the health care system. We are contacting you because you have actually used two parts of the system, first the hospital and now Home Care. We need to know your views, as a consumer, about how the different parts of our health care system should work together.

WHAT ARE WE ASKING YOU TO DO?
If you choose to be part of the study, a researcher will come to talk to you, for about an hour, about your experiences leaving hospital and coming home. She will ask some questions about the coordination of services between the hospital and Home Care. Your views are very important. There are no wrong answers. Your answers are what is needed. Anything that you tell the researcher will be kept strictly confidential.

WHO IS THE RESEARCHER?
The study is being done by Mrs. Alexandra Harrison who is a researcher from the Faculty of Medicine at the University of Calgary. Alex has worked in health care for many years. She has Master's degree in medical science from the University of Calgary. She is doing this study as part of a thesis for her doctorate degree.

WHAT IF I DO NOT WANT TO BE A PART OF THIS STUDY?
If you do NOT want Alex Harrison to contact you please call Home Care and tell us. Call Mrs. Jerry McAra at 228-7568. Tell her, or leave message for her, indicating that you do not want to be part of the coordination study. If you do not wish to be part of the study please call within 2 days of receiving this letter. If we do not hear from you, Alex will telephone you about the study. If you do not want to be interviewed, this will not affect your Home Care or any other health services.

HOW DO I BECOME PART OF THE STUDY?
If Home Care does not hear from you; Home Care will give Alex Harrison only your name and telephone number. Alex will call you to explain more about the study and ask if you are willing to have her come and talk to you in person. If you are willing to be part of the study Alex will meet with you in your home or another location which is convenient for you.

Thank you very much for reading this letter. If you agree, and are chosen to be part of this study, Alex Harrison will call you within the next three weeks.

Yours sincerely,

Brenda Hannah
Assistant Director
Calgary Health Services
Home Care Program
Community health services provided by the Calgary Regional Health Authority
P.O. Box 4016, Station "C", 320 - 17th Avenue S.W., Calgary, Alberta T2T 5T1 Tel: (403) 228-7400 Fax (403) 245-1736

APPENDIX II. A. 3
June 1995

GUIDE
TELEPHONE CALL TO CONSUMER

INTRODUCTION
Hello (Mrs. or Mr.) _____. My name is Alexandra Harrison. I am a researcher at the University of Calgary. I am calling you about the letter that was sent to you from Home Care. The letter was about a study that I am doing on health services in Calgary.
Questions
. Is now a convenient time for us to talk?
. Is it alright with you if I explain more about the study?

PURPOSE
There have been many changes in health care in the province of Alberta and in the Calgary Region. One of the reasons for making changes is to improve the coordination between various parts of the Health Care system. To decide if different parts of our health care system are working together, it is important to talk to people who have actually used the system. I understand that you have recently come home from the hospital and that you will be having someone from Calgary Health Services come into your home for a few weeks.
Questions
. Has the Home Care nurse or therapist called you yet?
. Has she been to see you yet?

PARTICIPATION
I would like to hear about your experiences leaving hospital and coming home. Your views are very important. There are no wrong answers. Your answers are what is needed. This is a research study to help us understand more about the health system in Calgary. If you decide not to be interviewed, this will not affect the health care you receive. If you choose to be part of the study I would like to meet with you for about an hour.
Questions
. May I meet with you in person? I would be happy to come to your home or meet you in any other location that is convenient for you.
. Could we set a day and a time for our meeting?
If you would like some time to think about this I would be happy to call back whenever you wish.

REFERENCES
Please feel free to call me at any time if you have any questions. My telephone number is 251-6273.
If you would like to verify anything about the study you could contact my supervisor: Dr. M. Verhoef at the University of Calgary, @ 220-7813; or Mrs. Brenda Hannah, the Assistant director of Home Care @ 228-7480.

APPENDIX II. A. 4.

THANK YOU LETTER TO CONSUMER

97 Woodpath Terrace SW
Calgary, AB T2W 5Z6

Date

Dear Mr. or Mrs. _____

Thank you very much for meeting with me the other day. I really appreciated hearing about your experiences when you came home from the hospital and your views about coordination. Your participation in this study is very important. Your comments will help us understand what people (like you) who actually use health services think is needed so that the different parts of our health care system work together.

As we discussed, when I analyze the information from the interviews, I may call you back to ask a few questions about what you told me to make sure that I really understand what you meant, or to ask your opinion about what I am finding. In addition, at the end of the study I will send you a report of the findings. If you should have any questions, please feel free to call me.

Thank you again for your help.

Yours sincerely,

Alexandra Harrison
251-6273

APPENDIX II. A. 5.

INTERVIEW GUIDE

November 1996

THE CONSUMER'S VIEW OF COORDINATION

Interviewer A. Harrison

NAME OF RESPONDENT _____
ADDRESS _____
TELEPHONE NUMBER _____
INTERVIEW: DATE _____ TIME INTERVAL _____
REGISTRATION DATE WITH HOME CARE _____

INTRODUCTION

There have been many changes in the way Health Services are organized in the province of Alberta and the City of Calgary. One of the reasons for making changes is to improve the coordination between various parts of the Health Care system. The purpose of our interview today is to learn what you as a consumer think is important about the coordination of the services you received in the hospital and the services you are now receiving from Home Care.

1. DESCRIPTION OF PERSONAL EXPERIENCE

Can you tell me about your experience:

A) Leaving hospital
B) Arriving home

2. THE TRANSITION FROM HOSPITAL TO HOME

A) DESCRIPTION - Would you describe your transition from the hospital to your home as positive or negative?

B) PREFERENCE - Would you prefer to be in hospital or at home?

C) TIMING - From your perspective was the time right for you to come home? Would you like to have come home a) sooner, b) when you did, or c) stayed in hospital longer?

D) HEALING - Do you think you will get better faster a) at home or b) in the hospital or c) at about the same rate?

E) PREPARATION - Did you feel ready to come home?

F) SUPPORT- Did you have enough support to go home A) from the health care system b) from your family or friends?

G) CONFIDENCE - Did you feel confident about going home? Why did you answer Yes or No?

H) FUNCTION - Were you able to function reasonably well at home? What helped you manage at home?

I) CONTROL - Did you feel in control of things when you were getting ready to come home and when you got Home?

J) FINANCES - Were there any financial implications for you in leaving the hospital and receiving care in your home?

K) CHANGES - Are you aware of any recent changes in Health Care? Do you think these changes have had, or will have an effect on your own health care?

3. COORDINATION

A. What does coordination mean to you?
B. What does coordination in Health Care mean to you?
C. Did you think there was coordination between the health care services you received in hospital and the care you are now receiving in your home? Could you give me some examples of why you answered (yes or no) to this question.
D. Were there gaps between the services provided in hospital and the services provided at home?
E. Are some of the services provided at home duplicating or repeating the services you had in hospital?
F. What do you think is important about the coordination of services for people who leave hospital but require care in their home?
G. Any other comments about your experience?

4. QUESTIONS FROM THE LITERATURE

A. INTRODUCTION

Do you think the following things are related (or important) to coordinating the care you received in the hospital and the care you are now receiving at home?

B. OBTAINING CARE (Alter & Hage Category - ACCESS)

Some people think that being able to obtain the care you need is a part of coordination. What do you think?
- Is this related to coordination? Is it important to coordination?

C. COMPLETENESS (Alter & Hage Category - COMPREHENSIVENESS)

Some people think the kind and amount of care that a person receives is a part of coordination. What do you think?
- Is this related to coordination? Is it important to coordination?

D. CONSISTENCY (Alter & Hage Category - COMPATIBILITY)

D.i) FIT (Congruence in Expertise)

Some people think it is important that the care you receive at home 'fit' with, or is it consistent with, the care that you received in hospital? What do you think?
- Is this related to coordination? Is it important to coordination?

D.ii) AGREEMENT WITH CONSUMER (Congruence with Consumer)

Some people think it is important that the people who provide your care agree with you about your care? What do you think?
- Is this related to coordination? Is it important to coordination?

E. COMMENTS ABOUT ANY OF THESE CATEGORIES

THE CONSUMER'S VIEW OF COORDINATION
Researcher A. Harrison

Information About the Consumer
Who Participated in the Interview

Introduction
I would like to include some information about who you are. This information is not intended to identify you personally, but rather to provide background about the people who participated in the study. All information about you as an individual will be kept strictly confidential. We can skip any questions that you would rather not answer or add anything which you think should be included.

AGE OF RESPONDENT _____

MALE OR FEMALE _____

OCCUPATION _____

ETHNIC GROUP _____

REFERRING HOSPITAL _____

REASON FOR HOSPITAL STAY _____

LENGTH OF TIME IN HOSPITAL _____

REASON FOR HOME CARE _____

TYPE OF HOME CARE SERVICES_____

FREQUENCY OF HOME CARE SERVICES _____

DURATION OF HOME CARE SERVICES_____

GENERAL HEALTH_____

LIVING ARRANGEMENTS _____
(eg. living alone, with a partner, with another family member)

ADDITIONAL INFORMATION (From Consumer or Interviewer)

_____

_____

APPENDIX II. B.

NUD*IST INDEX SYSTEM FOR THE SUDY

Q.S.R. NUD.IST Power version, revision 3.0.4d GUI.
Licensee: Alexandra Harrison.

PROJECT: CONSUM1, User Alex Harrison, 7:13 pm, Nov 13, 1997.

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(5 7)	/Other/System

COORDINATION SUMMARY

APPENDIX II. C. 1.
May 1997

INTRODUCTION

This summary is based on talks with patients who were in hospital and then received care at home.

WORDS TO DESCRIBE COORDINATION

The people I talked with used many different words to describe what coordination is, or what it means. The words they used include: cooperation, connection, continuity, working or linking together, getting along, team work, the right timing, and treating the whole person not just one part.

THEMES ABOUT COORDINATION

Ideas that came up many times and have a more than one part have been called themes. These are the themes that I was told are important to coordination.

People - Many people have an important role in helping to coordinate care. The people who were mentioned most often were the nurses in hospital and in Home Care, and the doctors, both family doctors and specialists.

Informed - There were two ways that being informed is important to coordination.

1. Health care staff should be informed about the services or procedures that patients will need.
2. Health care staff should be aware of any special health needs of the individual they are caring for.

Communication - There were also two ways that communication is important to coordination.

1. There needs to be communication between health care providers.
2. There needs to be communication with the patient.

SUPPORT FROM THE HEALTH CARE SYSTEM

Things that patients found helpful for dealing with the change between the hospital and their home include:

- A visit to the patient by the Home Care nurse while the patient was in hospital;
- A telephone number to call if the patient has health problems at home;
- A regular phone call from the Home Care nurse to see how things are going;
- Written instructions about surgery, or therapy, or medicines etc.;
- Having the chart at home so various health care people can look at it;
- Explaining things to the patient and including the patient in decisions about treatment.

CONCLUSION

I would like to know if this summary includes the things you think are important about coordination. I will call you soon. Thank you very much for your help.

APPENDIX II. C. 2.

COVERING LETTER TO CONSUMERS

Draft 22 May 1997

Dear ------

You may recall that we met a few months ago after you came home from the hospital. We talked about your health care at home after you left hospital. I have now completed my visits. I have started to review what people told me about the coordination of care between the hospital and Home Care.

I would like to know if the enclosed summary includes what you think is important about coordination. Since I spoke with many people, there may be more included than just the things that you and I talked about. Does this summary contain the things that you think are important about coordination? Is there any information in it that you think is incorrect and should not be here?

I will call within the next two weeks to talk to you about the summary.

Thank you again for your help with this work.

Yours sincerely,

Alexandra Harrison

APPENDIX II.D.

CONSENT FORM

RESEARCH PROJECT: The Consumer's View of Coordination as a Measure of Health System Performance

INVESTIGATORS: Alexandra Harrison O.C.(C.) Msc.(Med.Sci.)
Marja Verhoef, PhD
SPONSOR: University of Calgary, Faculty of Medicine, Department of Community Health Sciences

---

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

1. PURPOSE OF RESEARCH

There have been many changes relating to health care in the province of Alberta and in the Calgary Region. One of the reasons for making changes is to improve the coordination between various parts of the Health Care system. To decide if different parts of our health care system are working together, it is important to understand what coordination means to you as a consumer who has actually used two parts of the system, first the hospital and now Home Care.

2. RESEARCH DESIGN

This study uses a method called Grounded Theory. That means that I will be developing a model or a theory about what coordination means to consumers. I will be basing this theory on my interviews with people like you who were in hospital and now have health care services provided to them by in their homes by the Home Care division of the Calgary Regional Health Authority.

3. PARTICIPATION

If you choose to be part of the study, I would like to meet with you for about an hour to hear about your experiences leaving hospital and coming home. I will ask some questions about the coordination of services between the hospital and Home Care. Your views are very important. There are no wrong answers. Your answers are what is needed. If you agree, I would like to tape record our meeting so that I don't forget anything that you tell me. As I begin to analyse the interviews, if you agree, I may call you back to ask a few questions about what you told me to make sure that I really understand what you meant or to ask your opinion about what I am finding.

4. CONFIDENTIALITY
As a health care professional and a researcher, I am obligated to keep any information that you share with me strictly confidential. I will be having someone else type up our interview but they will not have your name. I will identify your tape by a number and no one but me will know what your number is.

5. STORAGE AND DISPOSAL OF DATA
I will read the typed version of the tape recording of our interview to ensure it is correct. Then I will erase the tape. The typed version of our interview will be stored in a locked cabinet for a minimum of six years. When the information is destroyed, the questionnaires and the text of the interviews will be shredded.

6. BENEFITS OF THE RESEARCH
To decide how well our health care system is working, we need to ask people like you who use different parts of the system what kinds of things are important to them. Then, when we measure if our health system is doing a good job, we can make sure that the views of people like you who use the system are taken into account. This kind of research is important to help us ask the right questions when we try to assess how well the health care system is working. You might experience indirect benefits from this research, in the form of a health care system that is more aware of (and hopefully more responsive to) your needs.

7. IMPLICATIONS
Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free not to participate in this study without jeopardizing your health care. If you have further questions concerning matters related to this research project, please contact: Mrs. Alexandra Harrison at 251-6273.

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

_____ _____
Participant Date

_____ _____
Investigator Date

_____ _____
Witness Date

A copy of this consent form has been given to you.

GLOSSARY APPENDIX III.

CALGARY REGIONAL HEALTH AUTHORITY (CRHA) - one of 17 health regions that were established in Alberta by the provincial government in 1994.

CLINICAL INTEGRATION - the extent to which patient care services are coordinated across various functions, activities and operating units of a system. Clinical integration subsumes horizontal and vertical integration (Devers et al., 1994).

COORDINATION - is the synchronization of services provided to the consumer in the transition from hospital to Home Care. It is one mechanism for achieving organizational integration. The focus of coordination is the consumer and the services that he or she receives.

CONSUMER - the recipient of health care services. All participants interviewed for this study were discharged from an acute care hospital into the short-term Home Care Program of the CRHA.

HOME CARE - the Home Care Program "enables people to live independently in the community. Services provided are sensitive to the individual's assessed needs with the goal of maximizing control and responsibility for the individual and family". Home Care has four client groups: short-term care, long- term care, palliative care, and pediatric care. (Calgary Health Services May 1994).

HORIZONTAL INTEGRATION - the coordination of functions, activities, or operating units that are at the same stage in the process of delivering services (eg. consolidation of hospitals) (Gilles et al., 1993).

INTEGRATION - is an organizational attribute; it relates to the linkages between differentiated, interdependent elements of the organization, for example between two divisions or sectors. Coordination is one mechanism for achieving organizational integration. The focus of integration is the organization.

INTEGRATED DELIVERY SYSTEM - a network of organizations, usually under common ownership, that provides, or arranges to provide, a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally responsible for the outcomes in health status of the population served (Leatt et al., 1996).

ORGANIZATION - a purposive, but incomplete, social system that directs concerted collective action toward a common goal by processing raw materials, people and information and delineates a division of labour, roles and relationships, and coordination mechanisms (Baker 1992).

ORGANIZATIONAL SYSTEM - is a set of interdependent parts that relate in the accomplishment of a common goal (Devers et al., 1994).

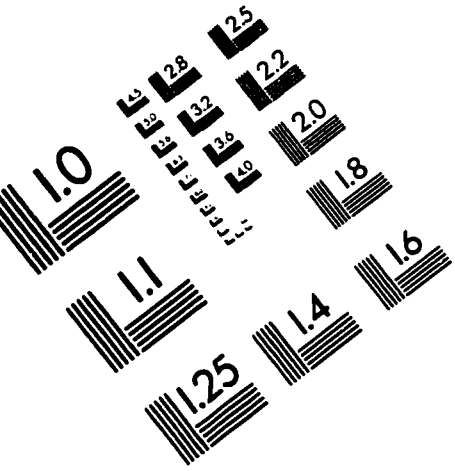
ORGANIZED DELIVERY SYSTEM - see Integrated Delivery System.

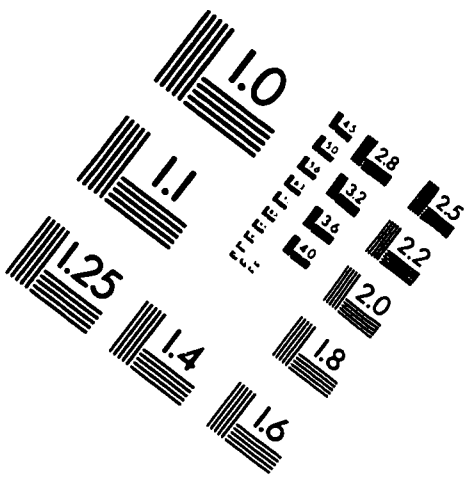
SHORT-TERM CARE - One of the four groups of Home Care Clients. These clients require care for less than 90 days (Calgary Health Services May 1994).

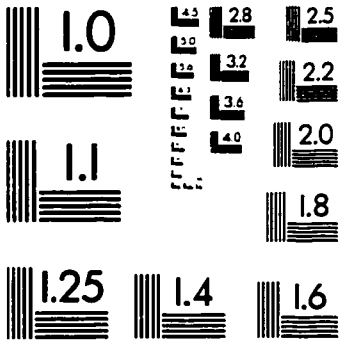
REGIONALIZATION - the transfer of greater control and decision making for the delivery of health services from the provincial government to local health authorities.

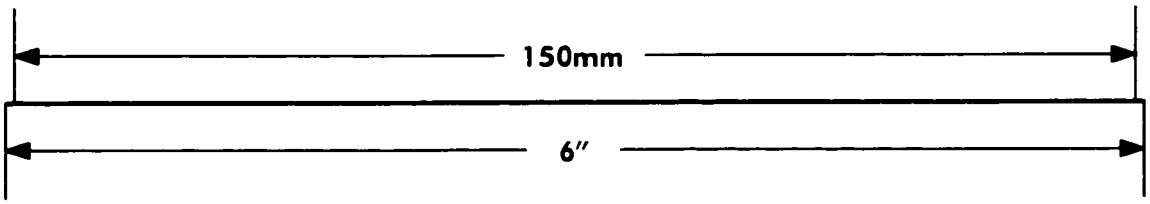
VERTICAL INTEGRATION - the coordination of functions, activities, or operating units that are at different stages of the process involved in delivering patient services (Gilles et al.,1993).

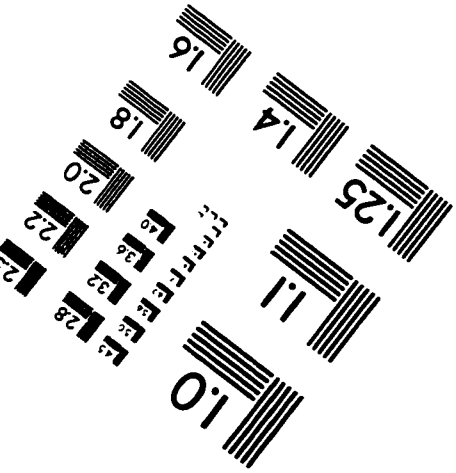
IMAGE EVALUATION
TEST TARGET (QA-3)

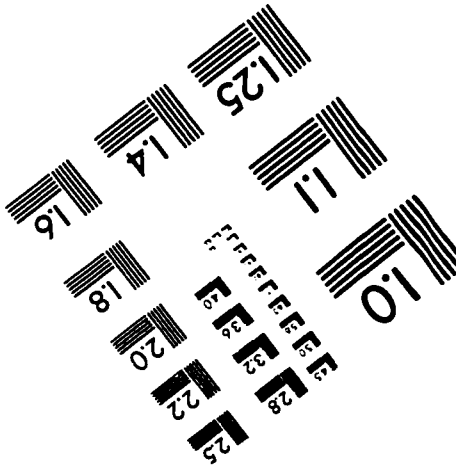












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