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Anne Brasset-Latulippe
AUTEUR DE LA THÈSE / AUTHOR OF THESIS

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FACULTÉ, ÉCOLE, DÉPARTEMENT / FACULTY, SCHOOL, DEPARTMENT

A Model of Continuity of Care in the Context of Women's Mental Health: An Exploratory Study of an Interprofessional Team Approach to Eating Disorders

TITRE DE LA THÈSE / TITLE OF THESIS

Craig Kuziemsay
DIRECTEUR (DIRECTRICE) DE LA THÈSE / THESIS SUPERVISOR

CO-DIRECTEUR (CO-DIRECTRICE) DE LA THÈSE / THESIS CO-SUPERVISOR

Ivy Lynn Bourgeault

Patrick O'Byrne

Gary W. Slater
Le Doyen de la Faculté des études supérieures et postdoctorales / Dean of the Faculty of Graduate and Postdoctoral Studies

Master Thesis

A Model of Continuity of Care in the Context of Women's Mental Health: An Exploratory Study of an Interprofessional Team Approach to Eating Disorders

Anne Brasset Latulippe

MSc. Degree in Health Systems

Telfer School of Management

University of Ottawa

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Supervisory Committee

Dr. Craig Kuziemsky, Telfer School of Management, University of Ottawa

Dr. Ivy Bourgeault, Faculty of Health Sciences, University of Ottawa

Dr. Patrick O'Byrne, Faculty of Health Sciences, University of Ottawa

Abstract

Objectives

The overall goal of this research was to study continuity of care in the context of team based care delivery to support adolescent women's mental health issues, specifically Anorexia or Bulimia. I used the three concepts of continuity of care described by Haggerty et al. (2003): relational, managerial and informational continuity, to develop an exploratory model of continuity of care for women's mental health. To research question was how are health care professionals providing continuity of care and collaborative patient centred care in the case of adolescent/women's mental health as represented by the eating disorders, anorexia and bulimia.

Methods

Data collection took place in the eating disorder program in a tertiary care paediatric hospital. The study included 36 participants including: psychiatrists, family physicians, psychologists, nurses, dietician, child and youth counsellors, medical and psychological interns and residents, and art therapist. Data sources included non participant observation of team meetings (approximately 20 hours) of inpatient, day hospital and outpatient clinics as well as 10 semi-structured interviews with health care professionals. Constructivist Grounded theory method was used to analyze the data.

Results

In terms of the continuity of care and how it unfolds, the three types work in a cyclical process. It starts with informational continuity, with the team learning with and from the patient. Once all the information is put together managerial continuity begins to form, ,as does relational continuity. When the patient is close to discharge informational continuity increases within the team, as well as between the family and different actors in the community.

From the constructivist grounded theory analysis, fives themes emerged as dimensions that impact continuity of care: political, clinical, social, financial, and geographical.

Conclusion

The professionals can better understand the process of continuity within their team. There is now empirical evidence on the interaction of the types of continuity. At the policy level, the types of remuneration played a role in the process of continuity. Next steps include clarifying the patient perspective.

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Dedication

Je dédie ma thèse de maîtrise à mon père Jean qui malheureusement n'a pas pu voir le fruit de mon travail achevé. Je sais cependant qu'il m'accompagne toujours. J'ai également une pensée spéciale pour ma mère Murielle, mon amour Louis-Alexandre et ma soeur Marie-Andrée pour m'avoir insufflé le courage de continuer après le départ de papa. Je vous aime de tout mon coeur.

Anne, November 2010

Chapter 1-Introduction

One of the primary goals of the healthcare system is to provide quality of care to the population. One of the steps to achieve it is through better understanding of the processes that are happening within health services. Continuity of care is an important and complex process that is required to achieve quality of care. Through this thesis, I aim at answering the following research question: how are healthcare professionals providing continuity of care and collaborative patient centered care in the case of adolescent and women's mental health as represented by the eating disorders, anorexia and bulimia? The objectives are:

- To understand how the types of continuity of care- relational, management and informational- as described theoretically by Haggerty et al. (2003), interact during the processes of care delivery.
- To explain how continuity of care functions and unfolds in a real-life setting for example at critical points of care such as during discharge.
- To develop a theoretical model that explains how healthcare teams operationalize continuity of care in the context of women's mental health.

This chapter introduces the concepts of team work and continuity of care, describes the research question, contribution to existing research, methodology, and provides a summary of the findings, and an outline of the dissertation.

1.1 Team Work and Continuity of Care: The Need for a Better Understanding of Continuity of Care in a Team-based Setting

Improvements to the efficacy, effectiveness, and quality of care in the Canadian healthcare system have been explored from a variety of perspectives. Two of those perspectives are continuity of care and team-based care. According to the World Health Organization, Health Canada, and the Ontario Ministry of Health and Long Term Care, increased collaboration between healthcare workers is critical to improve continuity of care (World Health Organization, 2006 p.26; Way et al., 2000 as cited in Health Canada-Executive summary, 2003 p.2; HealthForceOntario, 2007, p.7). Current health policies in North American and European countries call for more effective delivery of accessible, continuous, and comprehensive care (D'Amour et al., 2008). Health professionals are thus confronted with the demand for both interprofessional and interorganizational collaboration (D'Amour et al, 2008). Healthcare professionals can no longer work in silos and this requires a shift in the perspectives regarding clinical labour (D'Amour et al., 2008).

The concepts and processes of healthcare teams have been studied quite intensively in different settings (Zeiss & Steffen, 1998; Kumar & Parkinson, 2001; Choi & Pak, 2006; 2007; Lanceley et al., 2008; Rodriguez et al., 2008), but only recently have studies begun to explore how communication and collaboration unfold between teams and organizations (Akhavain et al., 1999; D'Amour et al., 2008; Supiano & Gregory, 2008). From the literature review, I identified that most of the existing literature is on single-team settings, not on relations across multiple teams. I also identified that very few studies exist, for example, on the interaction between inpatient and outpatient teams who are taking care of the same population. That interaction is important because patients move from inpatient to outpatient settings during their journey

through the healthcare system. Recent research also strongly suggests that failures in the coordination of care are common and can create serious quality concerns (Bodenheimer, 2008). Coordination of care is a component of continuity of care, which is defined as "the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context" (Haggerty et al., 2003). Two elements were identified for continuity to exist: care of the individual patient, and care over time (Haggerty et al., 2003). However, the presence of these two elements alone is not sufficient to constitute continuity of care (Haggerty et al., 2003).

According to Wierdsma, "at a conceptual and operational level, the continuity of care concept has been criticized for its lack of clarity" (2009, p. 52). Therefore, there is a need for studies that explain how the concepts of continuity of care actually function and unfold as processes in a real-life setting, as well as how healthcare teams are operationalizing them.

This research builds on existing studies of continuity of care and takes the three concepts of continuity of care as described by Haggerty et al. (2003) in a multidisciplinary review. The first concept is informational continuity, which is defined as "the use of information on past events and personal circumstances to make current care appropriate for each individual" (Haggerty et al., 2003, p.1220). The second concept is management continuity, which is defined as "a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs" (Haggerty et al., 2003, p.1220). The third concept is relational continuity, and refers to "an ongoing therapeutic relationship between a patient and one or more providers" (Haggerty et al., 2003, p.1220).

1.2 Continuity of Care and Mental Health

Continuity of care is especially important in the care of mental health because the complexities of the care and the chronic nature of the illness require the intervention of more than one professional and often more than one service. Additionally, patients are frequently discharged from the hospital but are often readmitted, requiring a continuation of their care delivery. The Senate report by Kirby and Keon (2006) underlined the importance of collaborative care as a particularly promising means by which to address the prevalent mental health issues, as well as to "improve both access to, and the quality of, treatment and services at the first line level" (Kirby & Keon, 2006, p.125). Collaboration is a key process of continuity of care involving different healthcare professionals and services. The mental healthcare system in Canada is currently under review through the Mental Health Commission of Canada. In their framework for a mental health strategy in Canada entitled *Toward Recovery and Well-Being,* the Mental Health Commission of Canada presents 7 goals to be achieved (Mental Health Commission of Canada, 2009). Continuity of care is closely linked to goal number 5 of the Mental Health Commission's Framework: "People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs" (Mental Health Commission of Canada, 2009, p.11). In order to have seamlessly integrated services around the needs of individuals suffering from a mental illness, we need to better understand the process of continuity of care that comes from integrated services and leads to quality of care.

One concept included in continuity of care in the context of mental health is continuity of contact. It is important because it embodies the notion that regular contact with the patient is needed to efficiently manage and adapt the patient's goals, and to connect the patient with a

broad range of services (Haggerty et al., 2003). In mental health, the coordination of the different professionals involved is usually organized through a common goal and plan (Tessler et al., 1986, as cited in Haggerty et al., 2003).

1.3 Continuity of Care and Eating Disorders

"Recovery from an eating disorder encompasses a complex matrix of mental, physical, and social factors" (D'Abundo & Chally, 2004). After an extensive review of the literature on the epidemiology, diagnosis, and therapy of eating disorders, Walsh, Wheat, and Freund (2000) concluded that the treatment of eating disorders should involve a multidisciplinary approach including primary care providers, nutritionists, and mental health professionals (D'Abundo & Chally, 2004). Patients who receive team-based care for anorexia or bulimia often move between inpatient, day treatment, and outpatient services. Communication failures between these different teams impact the relational, management, and informational continuity of patient care. Therefore, the teams treating individuals suffering from eating disorders require a structure that allows integrated care, and a set of processes that support continuity of care. Study and analysis of the structure of an eating disorder team was selected for this research project. I was looking for a mental health program that provided inpatient care, day treatment, and outpatient care.

1.4 Methodology

I employed a constructivist grounded theory approach to answer how healthcare professionals are providing continuity of care and collaborative patient-centered care in the case of adolescent and women's mental health as represented by the eating disorders, anorexia and bulimia. Data collection took place in an eating disorder program in a tertiary care paediatric hospital. The study included 36 participants who comprised the healthcare team. Data sources

included non participant observation of team meetings, as well as 10 semi-structured interviews with healthcare professionals.

1.5 Contribution to Existing Research

Using the three concepts identified by Haggerty et al. (2003) as a foundation, I developed a theoretical model illustrating how the process of continuity of care is happening in a context specific to adolescents and women's mental health. The specific objective of this research is to shed light on the following question: how are healthcare professionals providing continuity of care and collaborative patient centered care in the case of adolescents and women's mental health as represented by the eating disorders, anorexia and bulimia? The significant findings of my research are:

1. The process of continuity of care, in the context of the eating disorder program, is operationalized in a circular process. Prior to the research project we did not know how the concepts were interacting together.

2. The process of continuity of care is influenced by five dimensions: social, clinical, environmental, political and financial.

3. Strengths and challenges of the participating healthcare team regarding the operationalization of the process of continuity of care were identified and recommendations were provided to improve the process.

1.6 Thesis Organization

After reviewing the literature on team-based care, continuity of care, and mental health in Chapter 2, I fully describe the methodology of the study in Chapter 3. I present the theoretical model developed and the results in Chapter 4. The discussion of findings, which includes linking the results to the existing literature, limits of the study and future research options are covered in Chapter 5. Conclusions are presented in Chapter 6.

Chapter 2-Literature Review

In order to provide background information on the complexity of the concept of continuity of care as well as the specific case of team-approached care for eating disorders, the search strategy employed for the literature review focuses on four main content areas: 1) healthcare teams, 2) continuity of care, 3) women's health, and 4) eating disorders. I conducted the first literature search using the PubMed database. I explored the database using Medical Subject Headings (MeSH) terms appropriate to the dimensions of my research project. I selected the following MeSH terms, which are linked to the main content areas:

- Continuity of patient care
- Comprehensive healthcare
- Case management
- Patient-centered care
- Advance care planning
- Patient care management disease management
- Interprofessional relations
- Patient care team
- Women
- Women's health services
- Women's health
- Women's rights

For more details on the combination of the keywords during the literature search, please refer to appendix 1. Figure 1 shows how these areas of the literature review fit together.

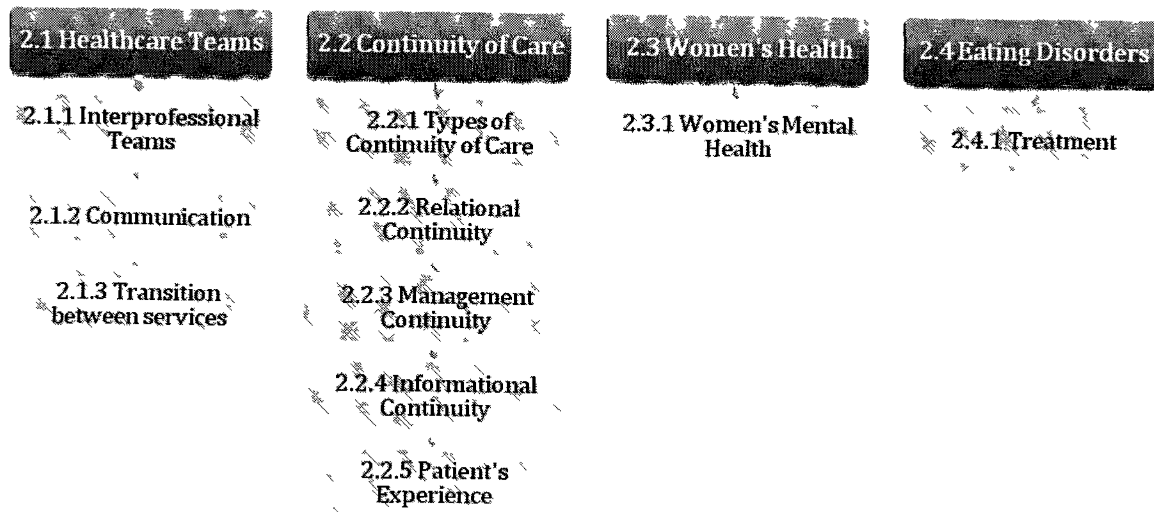


Figure 1: Framework of Literature Review

2.1. Healthcare Teams

The structure and organization of a practice, which includes staff mix, the use of multilevel clinicians, and the availability and convenience of colleagues for consultations, can affect the quality of care delivered to patients (Rodriguez et al., 2008). In fact, different types of teams exist in the literature and in settings. Choi & Pak (2006) did a literature review of the terms multidisciplinary, interdisciplinary, and transdisciplinary, to determine how these terms are used to describe different teams. They came up with the following definitions:

- *Multidisciplinary*: "Draws on knowledge from different disciplines but stays within the boundaries of those fields" (NSERC, 2004 as cited in Choi & Pak, 2006, p.359).

- *Interdisciplinary*: "Analyzes, synthesizes links between disciplines into a coordinated and coherent whole" (CIHR, 2005 as cited in Choi & Pak, 2006, p.359).

- *Transdisciplinary*: "Integrates the natural, social and health sciences in a humanities context, and in so doing transcends each of their traditional boundaries" (Soskolne, 2000 as cited in Choi & Pak, 2006, p.359).

Zeiss & Steffen (1998, p.553) describe structures similar to those defined by Choi & Pak, and include two additional definitions:

- *Unidisciplinary*: "Members from a single discipline; all members have the same role".

- *Intradisciplinary*: "Members from a single discipline, but at different levels of training; roles and responsibilities assigned by training level"

Another concept involved in describing teams is the process of team development. According to Zeiss & Steffen (1998), there are five steps in the process of team development:

1) *Forming:* Involves the actual formation of the team. The team addresses issues like deciding who is going to be part of the team, which patients will be served, what resources are available.
2) *Storming:* As the team works together, issues will inevitably arise and the team learns to voice disagreement in a way that communicates a desire to stay engaged and work out the issues fairly in a collaborative process.
3) *Norming:* If the group can work on areas of disagreement constructively, a working strategy evolves. These strategies can be thought of as "ground rules"
4) *Performing*: After a period of time the team reaches a high level of effectiveness and

"ground rules" become tacit knowledge.

5) *Team evolution*: Maintaining function in *Performing* mode consistently over time is unlikely and not a realistic team goal. As key staff members leave, the team will need to go through the previous steps again.

To be effective, the performing team will have to deal with dilemmas, which Zeiss & Steffen, (1998) identify as: interdependence, complexity, and disagreement. Interdependency dilemmas come from the fact that, by definition, interprofessional teams seek to work collaboratively, implying that some of the team members' skills overlap and the team needs to develop specific agreement (Zeiss & Stephen, 1998). This can lead to collaboration, which can be done through "knowledge of, and respect for diversity and shared abilities" (Zeiss & Stephen, 1998, p.558). Another dilemma that teams have to deal with is complexity. Interprofessional teams are created to manage complexity, which means, "understanding the interrelationships of each patient's biological, functional, social, and psychological problems" and should lead to effective comprehensive care (Zeiss & Stephen, 1998, p.559). However, teams need to organize themselves through conceptualization, and identify key issues to avoid information overload (Zeiss & Stephen, 1998, p.559). Finally, dilemmas can arise from disagreement within the team. Interprofessional teams need healthy conflicts arising from different perspectives and knowledge of members of the team. However, team members require effective communication skills to both overcome contradictory perspectives and integrate multiple perspectives (Zeiss & Stephen, 1998).

Choi & Pak (2006) describe in their literature review on different types of teams that the promoters of team work success include: good selection of team members, good team leaders, maturity and flexibility of team members, personal commitment, physical proximity of team

members, use of the Internet and email as supporting platforms, incentives, institutional support and changes in the workplace, a common goal and shared clarity and rotation of roles, communication, and constructive comments among team members. One way to support the development of these elements is through the creation of interprofessional team, which will be described in the next section.

2.1.1. Interprofessional team

Examples of different populations that require team approach to care are patients suffering from chronic illness, mental illness, and the frail elderly. It is often the complex nature of care needed for these types of patients that requires more than one type of healthcare provider. Also, the shortage of human resources in health and complex illness care suggests an interprofessional collaborative approach to care (World Health Organization, 2006 p.26; Way et al., 2000 as cited in Health Canada-Executive summary, 2003 p.2; HealthForceOntario, 2007, p.7). Collaboration is "an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of healthcare providers to synergistically influence the client/patient care provided" (Way et al., 2000 as cited in Health Canada-Executive summary, 2003 p.2). I can establish links between the concept of collaboration within team and the management, relational, and informational types of continuity of care as defined previously in this paper.

Collaboration was also explored in the context of interorganization. D'Amour et al. (2008) developed indicators for a structuration model of collaboration based on the concept of collective action in organizational sociology. The model can be used to analyze the ways in which complex and heterogeneous multi-level systems of actors collaborate, and apply to interprofessional and

interorganizational collaboration in healthcare organizations (D'Amour et al., 2008). The model suggests that collective action can be analyzed in terms of four dimensions (D'Amour et al., 2008):

1. *Shared goals and vision* refers to the existence of common goals and their appropriation by the team, the recognition of divergent motives and multiple allegiances, and the diversity of definitions and expectations regarding collaboration.

2. *Internalization* refers to an awareness by professionals of their interdependencies and of the importance of managing them, and which translates into a sense of belonging, knowledge of each other's values and discipline, and mutual trust.

3. *Formalization* (structuring clinical care) is "the extent to which documented procedures that communicate desired outputs and behaviours exist and are being used" (Bodewes, 2002 as cited in D'Amour, 2008, p.189). Formalization clarifies expectations and responsibilities.

4. *Governance* is the leadership functions that support collaboration.

According to D'Amour et al. (2008), the four dimensions and the interaction between them capture the processes inherent in collaboration. It is interesting to note that the first two dimensions are relational and pertains to the interaction between healthcare professionals and the last two are organizational, therefore can be influence at the policy level. Finally, the dimensions are subject to the influence of external and structural factors such as resources, financial constraints and policies (D'Amour et al., 2008). Zeiss & Steffen (1998) describe the process of team development within a single team that work in the same organization and D'Amour et al. (2008) propose dimensions that are needed for healthcare professionals to

collaborate effectively when they are working in different organisation. Conceptually, the two articles offer a continuum of what is necessary to reach collaboration.

2.1.2 Communication

Optimal communication is an essential feature of collaboration and continuity of care, since it is a part of and affects all relationships and relationship systems (Akhavain et al., 1999). Communication difficulties in teams have been identified in numerous studies (Kumar & Parkinson, 2007; Manojlovich & DeCicco, 2007; Reader et al., 2007). In their review of communication skills and error in intensive care units, Reader et al. (2007) conclude that effective communication, in the context of critical care teams, is crucial for ensuring patient safety and reducing susceptibility to error. They also emphasize the need to better understand and identify the specific communication skills important for safety within that type of team. **2.1.3**

2.1.3 Transition between services

Akhavain et al. (1999) also addressed the issues that need to be resolved between two interdisciplinary mental health teams in order for collaboration between the two units to occur as smoothly as possible. Among the issues were the problems with communication that can occur during the transfer of patients from one program to the other. Team members made assumptions about who was responsible for certain tasks, and when problems arose during the transitions, each team blamed the other for any difficulties that were encountered (Akhavain et al., 1999). To minimize miscommunication and promote collaboration between the teams, monthly joint administrative meetings were held instead of two separate meetings, which improved communication and were more cost effective (Akhavain et al., 1999). When a patient transfers from one team to another key information needs to be exchanged in an efficient manner. Not

enough information can impact safety of the patient as well as information overload. Supiona & Gregory (2008) described the key elements of a successful transition of terminally ill patients from inpatient hospital to home hospice care setting. Their study underscores the fact that during all transitions of care within the healthcare system, complete and timely communication is essential and leads to a successful partnership of the two settings (Supiano & Gregory, 2008). Communication and transition influence the three types of continuity of care described in the next section.

2.2 Continuity of care

A common understanding of continuity of care is still under development, but typically, continuity includes a variety of attributes that establish 'connectedness' in care, for example responding to patients' needs, and communication between patient and healthcare professionals and among service providers (Wierdsma, 2009). Additionally, the literature suggests that integrated care and continuity of care are not "objectives in themselves but are means to improve quality of care in terms of efficiency, access, effectiveness and patient satisfactions" (Gröne et al., 2002 as cited in Wierdsma, 2009, p.53)(Figure 2).

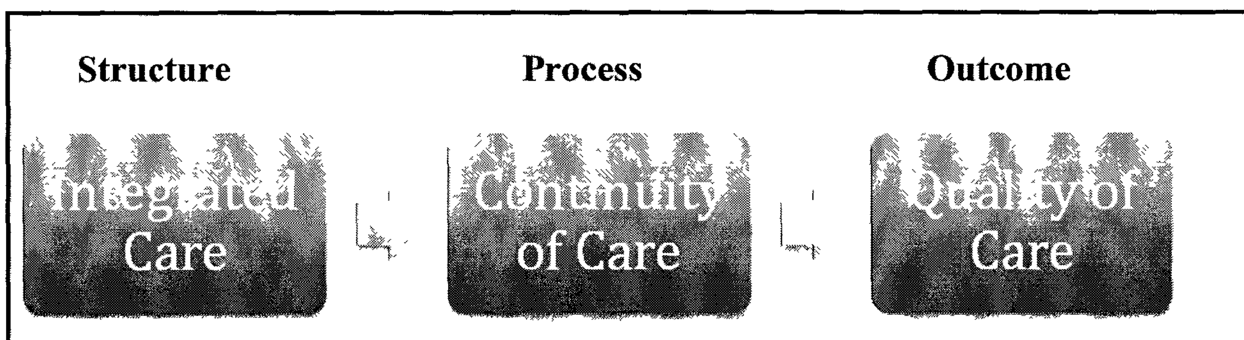


Figure 2: Continuity of care in the context of related concepts in health services research (Wierdsma et al., 2009, p. 53)

It is useful to develop a model that differentiates types of continuity of patient care as it improves the ability to link continuity with quality care outcomes. I found in the literature that "various ways of defining continuity and a lack of consensus about what is meant by continuity of patient care led to problems in determining its contribution to quality care" (van Servellen et al., 2003, p.185).

When studying the outcomes of continuity of care, it is not surprising to find that the results regarding the relevance of continuity of care to outcomes is relatively weak, especially the results related to health outcomes, because the very definition of continuity of care is under development. This correlation is hard to isolate because many researchers address continuity of care as only one aspect of many. Thus, continuity of care does not seem to be conceived as operating in isolation from other important features of care (van Servellen et al., 2003). In 2003, Adair et al. conducted a systematic review of the history of the concept of continuity of care in mental health services and its association with patients' outcomes. The study concluded that there is little evidence that continuity of care results in better patient outcomes, a conclusion that may be attributed to the underdevelopment of continuity of care measures. In a later study, Adair et al. (2005) explored the relationship between continuity of care and health outcomes in the context of severe mental illness. Although the authors claimed that they found a positive, consistent relationship between continuity of care and quality of life, community functioning, and service satisfaction among persons with severe mental illness, they also stated, given the study's observational design, that the causal direction of the association between continuity and outcomes cannot be determined (Adair et al., 2005).

King et al. (2008) used qualitative and quantitative methodology to study how experiencing continuity of care may affect health outcomes for cancer patients. Their results

suggest that the degree to which the patients experience continuity in their care may reduce their need for care (King et al., 2008). Still, continuity was not linearly associated with later quality of life or psychological status (King et al., 2008). Some studies reported that if interventions take into account the impact of continuity on patients' perceived control over care, their greater involvement in decision-making, and having more information about their illness and its treatment, then its relationship to quality care is further established (van Servellen et al., 2006).

Haggerty et al. (2003) advanced the understanding of the concept, especially the multi-dimensional nature of the concept, through a multidisciplinary review. The definition that arose from their study is that "continuity is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context" (Haggerty et al., 2003, p.1221). It is this definition that will be used in the context of this thesis because it takes into account the complexity of continuity of care and the patient's perspective. Additionally, the definition proposed by Haggerty is flexible enough to accommodate the different types of healthcare services including the one of this study, an eating disorder program.

2.2.1 Types of continuity of care

The basic processes of continuity of care need to be studied before looking at the impact on outcomes and quality of care. According to Haggerty et al. (2003), continuity of care is distinguished from other attributes of care by two core elements: care over time, and the focus on the individual patient. Additionally, three types of continuity emerged from the study by Haggerty et al. (2003): relational, management, and informational.

2.2.2 Relational continuity

Relational continuity can be defined as the ongoing therapeutic relationship between a patient and one or more healthcare providers (Haggerty et al., 2003). Relational continuity is important because it provides the patient with a sense of predictability and coherence (van Servellen et al., 2003). Relational continuity can be influenced by a number of factors: the number of other establishments with which the medical clinic had operational and formal care agreements, availability of scheduled visits in the evening, physician attachment to the practice community, and the ratio of a physician's practice consisting of walk-in care (Haggerty et al., 2008). Although van Servellen et al., (2003) mentioned that the relationships require additional research, the majority of the literature supports the relationships between continuity of care and patient satisfaction with care and provider, early diagnostic of patient conditions, improved compliance to treatment, and reduced resource consumption.

2.2.3 Management continuity

Management continuity, on the other hand, is a consistent and coherent approach to the management of a health condition that is responsive to patients' changing needs (Haggerty et al., 2003). For example, if someone suffering from schizophrenia was leaving independently in their apartment but suddenly become sick again and get evicted from their apartment because the person was disturbing the neighbours and end up being admitted to the hospital, that person will require more frequent visit from their psychiatrist to readjust their medication but also the support of the social worker to find a new apartment and organize support in the community as well as the support from the occupational therapist to manage the symptoms and develop a meaningful routine. Management continuity is especially important in chronic and complex diseases, when

care is provided by several providers who could potentially work at cross-purposes (Haggerty et al., 2003). This can be linked to the study by Bayliss et al. (2008), wherein elderly patients requiring complex care, including regular intervention from different healthcare professionals as their health needs changed, expressed the need for a care coordinator to help manage their care."

2.2.4 Informational continuity

Haggerty et al. (2003) defined informational continuity as the use of information about past events and personal circumstances to make current care appropriate for each individual. In the context of continuity of care between providers, Arora et al. (2008) emphasize that effective communication is critical to the coordination of care between healthcare providers and to ensuring patient understanding of care processes during times of transition. Indeed, the communication skills can lower the cost of coordination through improved information transfer (Arora et al., 2008).

2.2.4.1 Coordination continuity

Another type of continuity is the care between the physician and the specialist, which is referred to as coordination continuity (Haggerty et al., 2008). Haggerty et al. (2008) mentioned this type of continuity in the context of a primary care study. Coordination continuity is the delivery of services by different practitioners in a timely and complementary manner so that primary care is connected and cohesive for the patient (Haggerty et al., 2008). Because this type of continuity of care was not part of a literature review but was mentioned only in a single study on primary care and, its definition is quite similar to that of management continuity, I would argue that coordination is part of managing the continuity. Additionally, the majority of the

literature conceptualizes continuity and coordination as two different entities. Therefore, coordination continuity will not be used as a stand-alone concept in this thesis.

2.2.5 Patient's experience

Haggerty et al, (2003) stated that the unit of measurement of continuity of care should not be an attribute of providers or organizations but rather of individual patients. That is, continuity is how individual patients experience integration of services and coordination (Haggerty et al., 2003). Bayliss et al. (2008) explored the patient perspectives on components of "best" processes of care for persons with multiple physical morbidities (such as diabetes, depression, and osteoarthritis) to inform the development of future interventions to improve care. The results showed that patient needs were best met through emphasizing continuity, excellent bidirectional communication, and a caring attitude (Bayliss et al. 2008). The results also showed that patients would benefit if they had a care coordinator to help them negotiate the complex logistics of caring for morbidities and help with prioritizing self-management needs (Bayliss et al. 2008).

Naithani et al. (2006) explored patients' experiences and values with respect to continuity in diabetes care. Patients' accounts identified aspects of care they valued which were consistent with four dimensions of experienced continuity of care: (a) longitudinal continuity, meaning receiving regular reviews with clinical testing and provision of advice over time; (b) relational continuity, which refers to having a relationship with an usual care provider who knew and understood them, was concerned and interested, and took time to listen to them; (c) flexibility continuity, which is the flexibility of service provision in response to changing needs and situation; and (d) team and cross-boundary continuity, which represent consistency and coordination between different members of staff, and between hospital and general practice

(Naithani et al., 2006). The problems of lack of experienced continuity mainly occurred at transitions between sites of care, between providers, or with major changes in patients' needs (Naithani et al., 2006). If we link the dimensions identified by Naithani et al. (2006) with the review by Haggerty et al. (2003), the experience of care by a single patient, and care over time (longitudinal continuity), are the two core elements of the definition of continuity of care, and relational continuity is a type of continuity of care. I more detailed search of longitudinal continuity was not helpful since the authors are not agreeing on the definition of longitudinal continuity.

In sum, a question that arises from the literature on continuity of care is: how can continuity of care be assessed properly? Indeed, continuity of care can be assessed on many levels, such as according to the three types suggested by Haggerty (2003) - relational, informational, and management, and, from a participants' perspective- whether it is the health professional team or the patient. Still, the studies looking at the team/healthcare providers' perspective mostly focused on one type of continuity of care without really exploring how the different types were interconnected. The studies from the patients' perspective were more holistic and tried to be more inclusive of the different types of continuity of care.

2. 3 Women's Health and Continuity of Care

An important consideration of the patients' perspective vis-à-vis continuity of care is gender – the literature on women's health is instructive in this regard. Gender must be considered when delivering healthcare, because the differing social contexts of women and men can lead to gender differences in symptoms, illness behavior, etiology, diagnosis, and management (Lent & Bishop, 1998).

Lent & Bishop (1998) suggest that a gender issues perspective must be applied when identifying health priorities, and the social context must be recognized as an important element of women's health). They describe, for example, some initial ideas from a gender issues perspective because there is a lack of clarity about the actual meaning of a "gender issues perspective" and uncertainty regarding ways to make the concept practical and meaningful. They developed a general review of seven dimensions as a preliminary way of making the concept of a gender issues perspective more concrete (Lent & Bishop, 1998):

1. Women and men may have different life experiences that may affect both the patient's and the physician's perspectives on health-related issues.
2. Cultural diversity between doctor and patient can magnify the different life experiences mentioned above.
3. Stereotyped expectations for women and for men in our society can affect both physicians and patient, and thus healthcare in general.
4. Violence in intimate relationships has an impact on the physical and mental health of women, men, and children. The symptoms of the experience of violence can be demonstrated in a variety of ways.
5. Sexual orientation has an impact on healthcare.
6. Women and men differ in risk factors and presentation of many health problems.
7. Educational materials should use gender-neutral language whenever appropriate.

Similarly, Philips et al. (2003) propose the term "gender issues" not as a field of specialization but as a paradigm that recognizes the importance of the study of gender differences, and the need for multidisciplinary approaches to research. In addition, their paradigm

responds to real and perceived disparities in the roles, rights, and treatment of women (Philips et al., 2003). It also includes the values and knowledge of women and their own experience with health and illness, and reflects needs of the life cycle (Philips et al., 2003).

It is important to note that the field of interprofessional collaborative care is so new that very little examination of this trend has been done from a gender perspective. However, this is why we need to consider it.

2.3.1 Women's mental health

Mental health must be understood as a gendered concept since our very notions of mental health, mental illness, and madness arise from discursive practices that have positioned women as more vulnerable to being mentally instable (Barnes & Bowl, 2001 as cited in Morrow et al., 2007). Differences between women and men regarding mental health can be assessed by looking at the prevalence rate across gender. Indeed, seasonal affective disorder, eating disorders, panic disorders, phobias, and suicide attempts are higher in women (Morrow et al., 2007). On the other hand, men are more likely to suffer from substance abuse, antisocial personality disorder, early onset of schizophrenia, and completed suicide (Morrow et al., 2007). From a psychosocial perspective, women are more vulnerable than men to poorer mental health because of the ways they are socialized into particular social roles, which often results in lower self-esteem and greater risk for depression (Morrow et al., 2007).

Historically, women have been understood as located on the "irrational" side of the nature, therefore, it is not surprising that in Western thinking women, more than men, have come to be understood as mentally unstable by society (Morrow et al., 2007, p. 356). Additionally, the dominance of men working in medical science combined with sexist beliefs found in society

solidified this understanding of women, and henceforth psychiatry and psychology continue to view women through the lens of mental instability (Morrow et al., 2007, p. 356). The impact of this historical perspective on gender issues in healthcare is important to consider when researching the area of women's mental health. As Bird & Rieker (1999, p. 745) argue: "Researchers, clinicians and policy makers would understand and address both sex-specific and non-sex specific health problems differently if the social as well as the biological sources of differences in men's and women's health were better understood".

2.4. Eating Disorders

Eating disorders generally occur during adolescence and early adulthood and include anorexia nervosa, bulimia nervosa, and six other disorders that fall under the category *eating disorder not otherwise specified* (Chavez & Insel, 2007). Anorexia nervosa is characterized by severely restricted food intake and refusal to maintain body weight at a normal level (Wilson, 2005). Bulimia nervosa is characterized by recurrent binge eating, regular extreme compensatory behavior designed to influence body shape and weight, and negative self-evaluation that is unduly determined by body shape and weight (Wilson, 2005). Eating disorders can present with comorbidities such as depression, anxiety, obsessionality, substance abuse, and marked impairment which often last a lifetime, deeply impacting the women and their families (Chavez & Insel, 2007). Additionally, anorexia nervosa presents with a mortality rate of 5% per decade, which makes it one of the leading contributors to excess mortality among the psychiatric disorders (Chavez & Insel, 2007). Additionally, suicide attempts occur in approximately 3–20% of patients with anorexia nervosa and in 25–35% of patients with bulimia nervosa (Franko & Keel, 2006). "The serious health consequences, high rates of suicidality, and comorbidity in patients with eating disorders force treatment providers to constantly monitor each patient's

psychological and physical functioning" (Warren et al., 2009, p.28). Hospital-based treatment programs for eating disorders typically require a multidisciplinary team that can manage very severe cases (Stewart & Williamson, 2004). Eating disorders are strongly linked to women's mental health issues as 90% of individuals suffering from eating disorders are women (Health Canada, 2002).

2.4.1 Team-based approach to eating disorders

A multi-faced treatment is required to address the frequently complex influences of an adolescent's unique psychological and social characteristics as well as medical history that contribute to the development of the eating disorder. Such treatment encompasses individual, group and family therapy, nutritional therapy, and psychoeducational groups for clients and their families (Faith et al., 2003). An important aspect of the treatment process for teams addressing eating disorders is the coordination of the treatment and the collaboration between all healthcare disciplines involved (Stewart & Williamson, 2004). This means that the care team has to implement the treatment plan across all treatment modalities. To achieve this, it is important to establish a consensus of opinion about the structure, process, and content of the treatment plan for each patient (Stewart & Williamson, 2004). This is usually done through regular team meetings.

2.5 Summary of Literature Review

There is a gap in the healthcare literature regarding the relational, informational, and managerial types of continuity of care across healthcare providers in the context of inpatient and outpatient teams. The types of communication needed across teams have been explored in different circumstances that are apart from, but share resemblance with healthcare teams. Supiona & Gregory (2008) emphasize that communication across setting is important, but they did not

study how it happens in practice and what needs to be addressed. Additionally, asynchronous communication is a type of communication that occurs when teams are in different settings. It relates to the exchange of information that happens in different points in time, and dispersed or distributed communication is carried out in different places (Montoya-Weiss et al., 2001). Again, it seems this type of communication was not studied in depth in healthcare and in this study the assumption is made that teams addressing women's health need to attend to specific needs.

The literature review highlights the need to address inter-team communication to gain a better understanding of how continuity of care functions in mental health, and how it can be improved in order to have an impact on patients' outcomes and quality of care.

Table 1: Summary of Current Literature

	Existing Knowledge	**Knowledge gap**
2.1 Healthcare teams	• Types of teams. • Process of team development. • Chronic illness and mental illness require interprofessional collaborative approach to care. • Indicators for a structuration model of collaboration.	• How to optimize patient transfer from one team to another?
2.2 Continuity of Care	• Multidisciplinary review on the concept of continuity of care. • Relational, management, and informational continuity are defined. • Continuity of care is a process linked with integrated care and could lead to quality of care. • The unit of measurement of continuity of care should be the individual patient.	• Process of continuity of care in a team based context? • How the three types of continuity of care interact? • The lack of understanding of the process of continuity of care makes it hard to measure and therefore assess its impact on health outcomes.

	Existing Knowledge	Knowledge gap
2.3 Women's health and Continuity of Care	• Gender should be considered when delivering care. • Women and men may have different life experiences that may affect their perception of health related issues.	• There is a need to better understand the social and biological sources of differences in men's and women's health. • There is very little information in the literature regarding interprofessional collaborative care form a gender perspective.
2.3.1 Women's mental health	• Women are more susceptible than men to poorer mental health.	• There is a need to better understand the social and biological sources of differences in men and women's mental health.
2.4 Eating Disorders	• Specific criteria to diagnose the different kind of eating disorders. • High level of comorbidity in this population. • 90% of individuals suffering from eating disorders are women. • - The treatment typically requires a multidisciplinary team.	• How to optimize continuity of care with teams addressing eating disorders?

Chapter 3-Methodology

In this chapter, I will describe the methodology of my research project and the context in which it occured. Figure 3 illustrates the different methodological steps of the research project. The following sections then describe the elements of Figure 3. In section 3.1, I will discuss the research design, in section 3.2 the research methods, in section 3.4 the data analysis and in section 3.3 the research site.

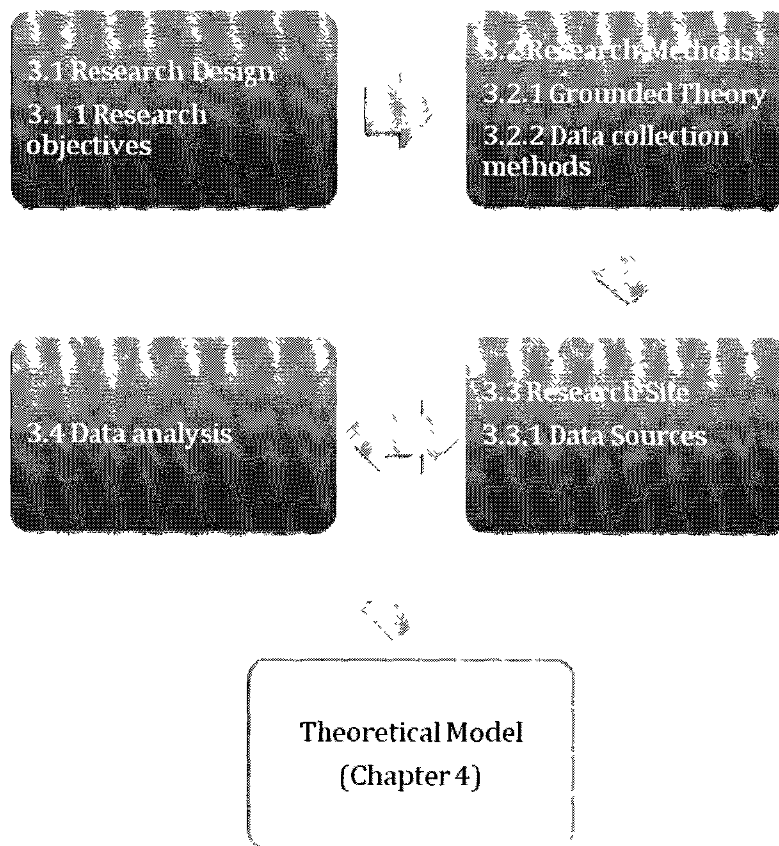


Figure 3: Methodological Steps of the Research Project

3.1 Research Design

Although continuity of care as been studied in the context of mental health there is still a need to explore how the types of continuity of care interact in an empirical setting. A qualitative approach is well suited to the study of mental health services because "qualitative research draws on practitioners' intuition and experience, so it can generate findings that are meaningful and useful to them" (Goering et al., p.146). Qualitative research methods enable organizations to gain a deeper understanding of processes and phenomenon, as they exist in their own unique environment (Miles & Huberman, 1994). By developing a model of continuity of care, the process that already exists will be formalized making implicit knowledge explicit in order to better understand how continuity of care is operationalized.

3.1.1 Research objectives.

This is an exploratory and descriptive study intended to address the knowledge gaps identified in Chapter 2 (please see table 1, section 2.5). It will investigate the concepts involved in continuity of care across different teams dealing with women suffering from eating disorders. As identified in the literature review, there is a need to learn more about team communication in order to have a better understanding of how continuity of care functions, and how continuity of care can be improved. Although there has been much research on continuity of care, there is a need to understand how the different types of continuity of care interact using empirical data. Through this study, I wanted to gain an understanding of how different healthcare team members interact to promote continuity of care, and to develop a theoretical model of continuity of care appropriate to the context of women's mental health.

3.2 Research Methods

3.2.1 Grounded theory.

Grounded Theory (GT) is a "qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon." (Strauss & Corbin, 1990).

Traditionally, a GT study does not begin with a preconceived theory that needs to be proven, but rather the theory emerges from the data. I used a constructivist grounded theory approach since the research is extending the concepts of continuity of care described by Haggerty et al. (2003) and not starting with a clean slate as Strauss & Corbin (1990) suggest. Constructivism assumes that individuals, including researchers, construct the realities in which they participate (Charmaz, 2006, p.187). This means "entering the phenomenon, gaining multiple views on it and locating it in its web of connections and constraints" (Charmaz, 2006, p.187). A constructivist approach to Grounded Theory places priority on the phenomena of study and sees both data and analysis as shared experiences and relationships with participants and other sources of data (Charmaz, 2006, p.130). A constructivist approach also acknowledges that while the resulting theory is an interpretation that depends on the researcher's view, it does not and cannot stand outside of it (Charmaz, 2006, p.130). Others authors like Glaser (1978 as cited in Sarker et al., 2001) argue that GT does not require the researchers to suspend all pre-existing theoretical knowledge, but instead encourages the development and enrichment of grounded theories by drawing upon (not driven by) broad theoretical approaches that are not in the same substantive area. Additionally, as argued by Kuziemsky et al. (2007), medical practice does not start with a null framework, so to improve the understanding of continuity of care in the context of team-based mental health, it

makes sense to build the model using types of continuity of care that have been identified through existing research. The chain of theory development starts with coding (Charmaz, 2000). Charmaz (2000, p.515) underscores that "we may use sensitizing concepts but only as points of departures from which to study the data. Line-by-line coding likely leads to our refining and specifying any borrowed extant concept". Therefore, when I analyzed the data, Haggerty's types of continuity of care, relational, management, and informational continuity were sensitizing concepts and starting points. However line-by-line coding then lead to the emergence of new codes. Figure 4 illustrates how I analyzed the data using a constructivist grounded theory approach starting with the types of continuity of care. The theoretical proposition of grounded theory is to make constant comparisons throughout the study between data collection and analysis with the objectives of identifying emergent themes, and refining, challenging, and elaborating on the developing thematic structure until theme saturation is achieved (Strauss & Corbin, 1998). Therefore, going back to the data collection will give a stronger definition of the phenomenon.

The hallmark of GT is three coding cycles: open, axial and selective coding (Strauss & Corbin, 1998). Open coding is an analytic process through which concepts are identified and their properties and dimensions are discovered in the data (Strauss and Corbin, 1998, p.102). This means that the researcher has to uncover, name, and develop concepts by opening the text and exposing the thoughts, ideas, and meaning contained therein (Strauss and Corbin, 1998, p.102). Axial coding is the process of relating categories to their subcategories. It is termed "axial" because coding occurs around the axis of a category, linking categories at the level of properties and dimensions. In selective coding, the process involves integrating and refining the theory until theoretical saturation occurs. Saturation occurs when no new themes emerge from data collection.

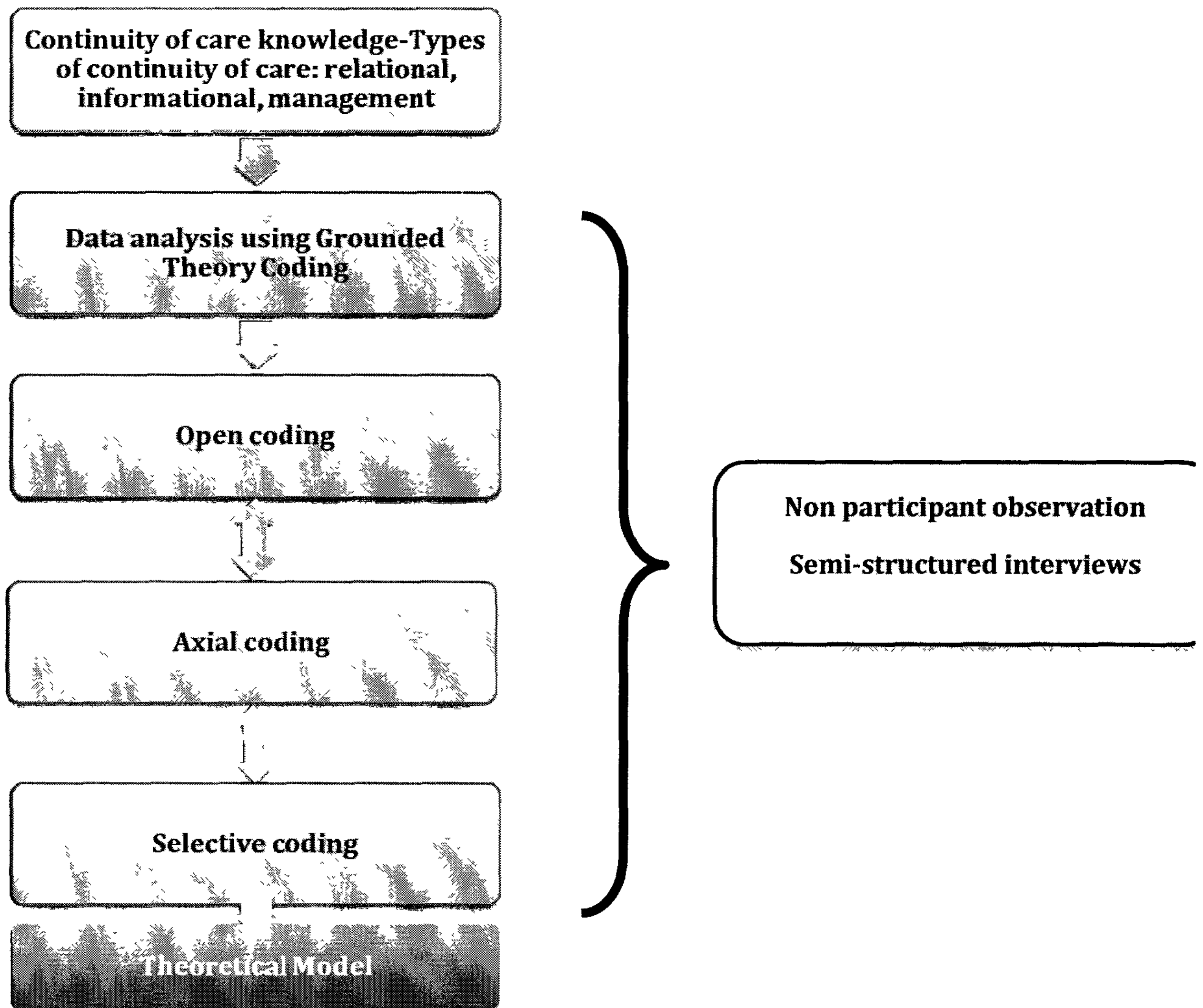


Figure 4: Conceptualization of data collection and analysis

The goal of this research is to explain and understand the interaction of specific team members addressing women's mental health issues in a context where the women must transition between different services. Therefore, I studied an eating disorder program that included three types of services: inpatient, day treatment and outpatient.

3.2.2 Data collection methods

The following qualitative methods are best suited to capture the complexity of healthcare: observations, focus groups, and interviews (Johnson & Barach, 2008). To establish the credibility of the study as suggested by Miles and Huberman (1994). Selecting two data types allowed collection of a rich dataset as well as providing triangulation through converging conclusions (Miles & Huberman, 1994). To study how team members addressed continuity of care and collaborative patient-centered care in the context of women's mental health, the data collection included: a) non-participant observation, and b) semi-structured interviews. The data collection occurred over a period of nine weeks. I did the interviews and the non-participant observation concurrently. I started with two pilot interviews to get a better understanding of the program and then I modified the initial interview protocol based on the pilot interviews. I began with observation, and then conducted the interviews between the team meetings, which occurred three times a week.

3.2.2.1 Non participant observations

During observations, the researcher takes field notes on the behavior and activities of the individuals at the research site (Creswell, 2003, p.185). Because I was doing non-participant observation, I did not play an active role in the meetings, although my present probably had some types of influence. The advantage of observations is that the researcher gains first-hand experience with study participants (Creswell, 2003). Therefore, I selected non participant observation because I taught that being emerge in the reality of the team meetings would give me a better understanding of how continuity of care was operationalized by the team members. The team meetings are a formalize structure of team work to exchange key information and improve

collaboration for that reason I assume it would be a key moments to experience the organization of continuity of care.

3.2.2.2 Semi-structured interviews

I conducted semi-structured interviews in-person, using open-ended questions. This enabled me to obtain historical information about participants, elicit views and opinions from them, and also to obtain clarification regarding some of the points I had noted during my observation (Creswell, 2003).

According to Strauss & Corbin (1998), the first step in developing a theory is to ask effective questions, which advance our understanding of the theoretical issues. In my case, this meant asking questions regarding continuity of care and patient-centred care. Because I was unfamiliar with the research site, I focused my interviews around sensitizing questions as suggested by Strauss and Corbin (1998, p.77). For example, I was interested in the process of providing care, who is involved in the process, how do caregivers define the situation, and what does it means to them. In the interviews included in my study, I modified the interview protocol and asked more theoretical questions regarding continuity of care in order to go deeper into the process of developing the theoretical model and to make connections between the different concepts found in the first interviews (Strauss & Corbin, 1998, p.77). Once my theory began to evolve from the initial interviews, I focused the next set of interviews on more practical and structural questions in order to assess whether my developing theory was logical, where the breaks in logic were, and where I should go next to gather data (Strauss & Corbin, 1998, p.77).

3.3 Research Site

The data collection took place in the Eating Disorders Program situated in a tertiary care paediatric hospital. The Eating Disorders Program treats adolescents between the ages of 9 and 18 years old. The Eating Disorders Program is comprised of three services: inpatient, day treatment, and outpatient. Figure 5 illustrates the continuum of care offered by the Eating Disorders Program. The goals of the Eating Disorder Program are:

- Medical stabilization and nutritional rehabilitation
- Improved psychological functioning
- Normalized eating
- Empowering and strengthening families
- Outcomes management research: demonstrating the effectiveness of the treatment provided and enhancing the services based on the research
- Education and training of community and provincial partners.

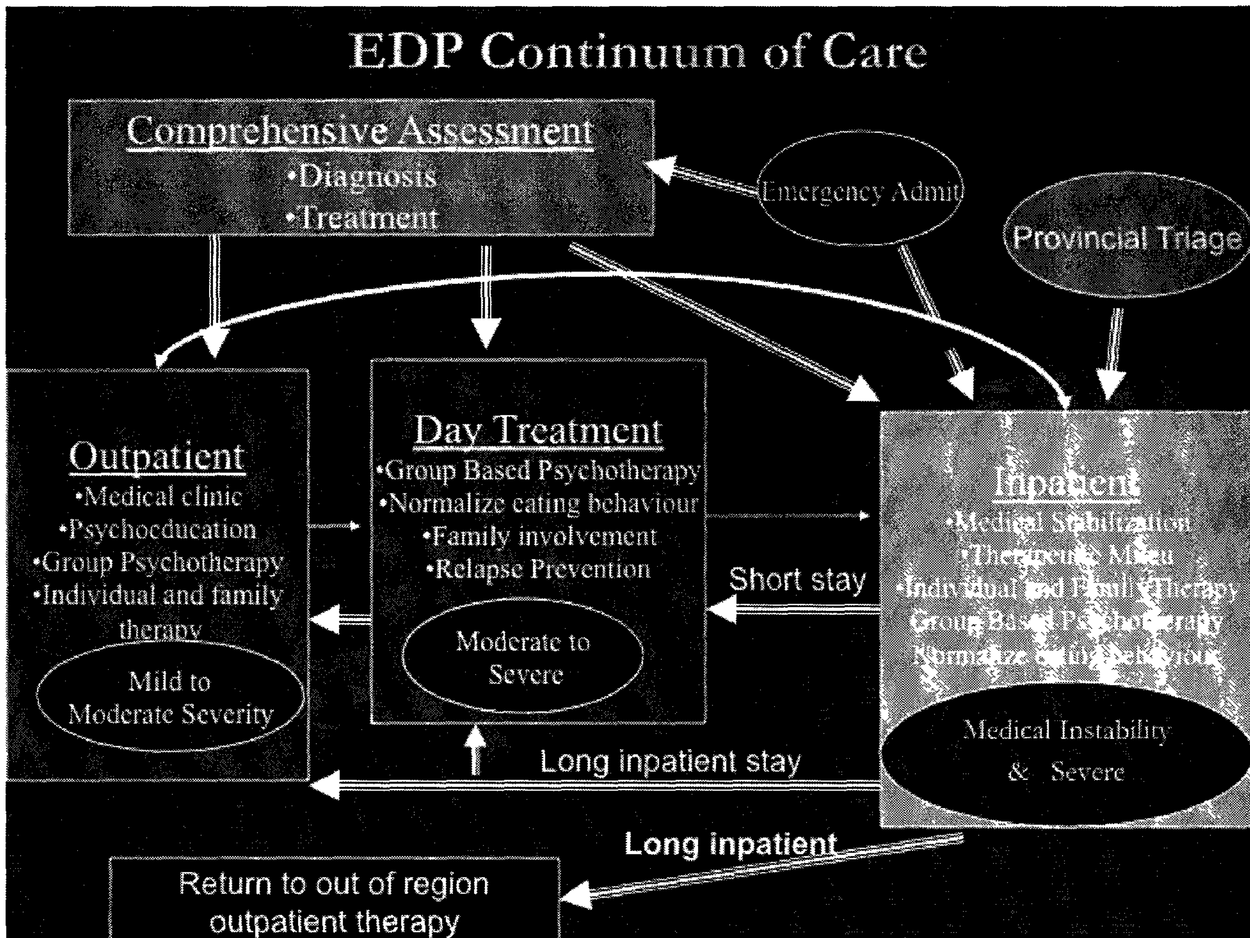


Figure 5: Eating Disorder Program Continuum of Care

I met with the clinical director of the program and she agreed to be a collaborator in this research project. The Eating Disorder program has a strong research based and at the time, the program was also involved with a consultant to better understand their patient flow. The clinical director thought that the research project on continuity of care would be an interesting addition. I selected the research site because the program had three levels of care inpatient, day treatment and outpatient service, which make it and interesting setting to look at transition between the services. Additionally, the profession within the program are quite diverse and the complexity of their continuum of care is interesting in terms of understanding how continuity of care operates.

The research project received ethical approval from the ethic board at the paediatric tertiary hospital where the study took place as well as from the University of Ottawa.

3.3.1 Data Sources

3.3.1.1 Sampling strategy

The sampling method for the selection of the participants was "purposeful sampling", which involved asking team members to participate in the interviews to ensure that the key actors are included and that I have a representative sample. Snowball sampling was also used to reach that objective. Once I received ethics approval, I first informed the participants about the study through and email with an information letter attached. I was then introduced to the team during one team meeting; during which I described the research project to them. I also gave each team members the information letter regarding the study (the same letter that they received through email). As suggested by the ethics board director, the consent for the non-participant information was implied and every time a new team member attended a team meeting, I gave them the information letter which gave them the option to opt out of the study. For the interviews, I recruited the participants by asking them directly if they were interested in participating. If they agreed, we selected a time and place for the interview that was convenient for them.

3.3.1.2 Participants

The participants in my study were the healthcare professionals that comprised the Eating Disorders Program team. This specific team was chosen because they were addressing adolescent and adult women's health issues. The nature of these disorders often require different care pathways, such as transferring the patient from inpatient care, to day treatment, and to the outpatient services on a regular basis. This variety of care pathways made it possible to study the

relational, informational, and managerial concepts of continuity of care described by Haggerty et al. (2003). The interprofessional clinical team was composed of psychiatrists, psychologists, adolescent health physicians, child and youth counsellors, nurses, dieticians, psychometrists and art therapists that work in different sections of the program. The program also receives support from high school teachers. However, the teachers do not participate in the team meetings with the other professionals.

I was able to observe 36 participants. No member of the team chose to opt out of the study. I gathered data regarding team functioning and how they operationalized continuity of care. The goal of the team meetings, or "rounds", as they called them, was to discuss each client in the inpatient services and in the day treatment services. If necessary, the team members also discuss clients from outpatient services. I was interested to see how decisions are made among professionals, how the patient or family perspective is included in the process, and how the healthcare professionals coordinate their activities to provide continuity of care. During observations I tried to be as unobtrusive as possible. I was seated at the back of the room while the team members were seated around the conference table. During the weeks that I did observations, I showed up at every meeting so the team members would get used to me being there. During the meeting, using a pen and paper, I recorded the team member's discussions as verbatim as was possible. I transcribed the notes I took onto a computer after the meetings.

I conducted 10 semi-structured interviews with the team members. The team members included: one nurse, two child and youth counsellors, two dieticians, one psychiatrist, one physician, and three psychologists/psychometrists. I was able to interview 27% of the 36 team members who were included in the non-participant observation which means I have a representative sample of the team members. The perception regarding continuity of care for each

profession present within the team was included in the data. I conducted all the interviews myself. The interviews were audiotaped and transcribed verbatim by a professional transcription service.

In order to preserve the anonymity of the participants I pooled the psychometrist, the psychologists and the art therapist under the pseudonym "PSY" and the psychiatrists and the physicians under the pseudonym "MD". Additionally, the nurses were "RN", the child and youth counsellor "CYC" and the dieticians "DT".

3.4 Data Analysis

Because grounded theory requires constant comparison between data collection and analysis, the interview questions were modified to elaborate on the developing thematic structure (Strauss & Corbin, 1998). The initial interview protocol is in appendix 1. The questions related to the role of the participant within the team, their perception of the process regarding decision-making, and their understanding of what is family centered care and continuity of care. They were also asked what are the strengths and weaknesses of the program regarding continuity of care, and to give examples of the each type of continuity of care (relational, informational and management) after being given the definition for each type. The interview protocol had two modifications based on the observation that staff coverage during the holidays presented a challenge to continuity of care that hadn't been previously considered when designing the interview protocol, and that more information was required regarding the three types of continuity of care.

Coding of the data collected in the interviews and the non-participant observation was done using NVivo ©, a qualitative data management software. I was responsible for the data collection

and analysis, with the support of my thesis supervisor. I transferred the interviews and the non participant observation into NVivo © and I coded line-by-line using the software. I wrote my memos of data collection and data analysis using Microsoft Word©. My thesis supervisor validated the data analysis. During the process of data collection and analysis we met approximately once a week over a period of 4 months to discuss and validate the coding and themes that were emerging from the data. I selected examples in the raw data and he validated the the codes that I assigned to the data. Additionally, he provided feedback on how to collect data to deepen the data analysis. For example, he suggested that I observe which types of continuity of care are associated with the care pathway. Once we determined the categories, the theoretical model was developed. The three types of continuity of care by Haggerty et al. (2003) were starting points and the data collection and analysis allow to discover and interpret which element were influencing it and how they were interacting.

It was specified in the ethics documents that to preserve anonymity, raw data could not be shared with the two research site collaborators (two clinical psychologists within the Eating Disorders Program). Therefore, at the end of the study, a slide deck describing the results of the data analysis, but omitting the raw data, was presented to the two collaborators. They validated the theoretical model and suggested that the care providers should be placed in the centre of the model, which was done. They also suggested that the results should be put in lay language when disseminated to the participants. This was done so that the data analysis and the model would "make senses" to a more general audience (Miles & Huberman, 1994). Validation of the data was done doing two types of data collection: interviews and observations. Additionally, I gathered the data over several weeks, which allowed for changes in team members that were going on holiday during the summer time.

In this study, saturation was reached after nine interviews and 20 hours of non-participant observation. Figure 6 is an example of axial coding. Informational continuity is a category and the subcategories clinical dimensions and social dimensions are emergent codes that were identified to give coherence to the emerging analysis (Charmaz, 2006).

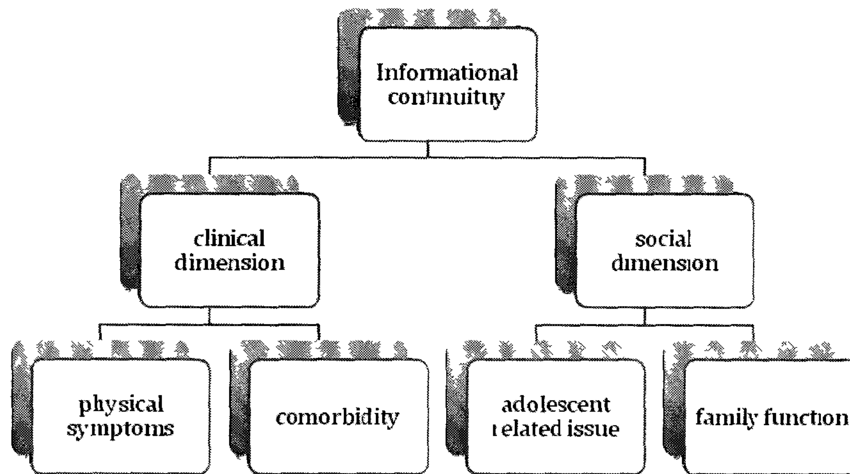
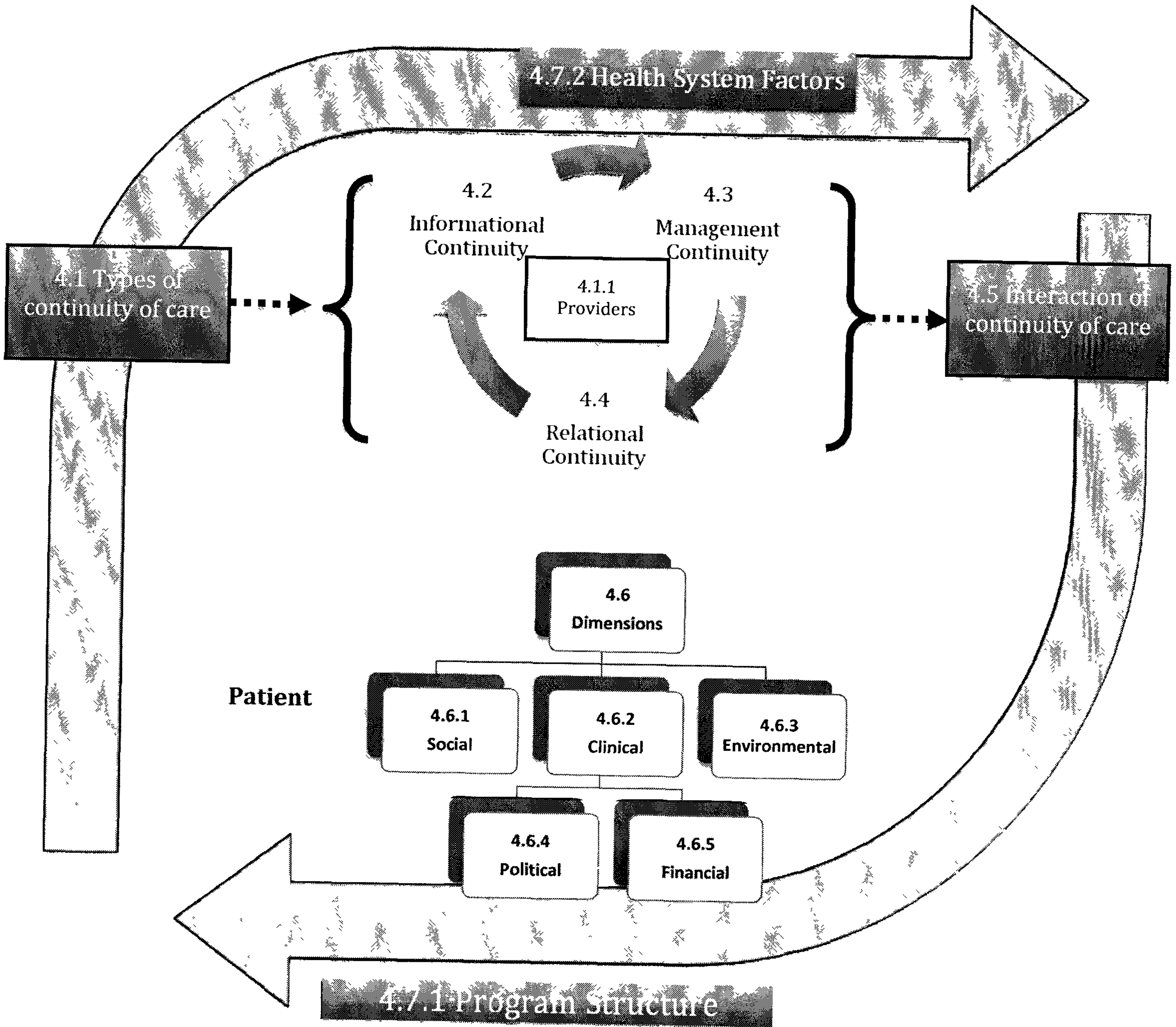


Figure 6: Example of axial coding

For the complete list of the open codes and examples of open, axial and selective coding please refer to appendix 3.

Chapter 4- Results

This chapter is divided into three parts. In sections 4.1 through 4.4 (part 1), I will present how the three types of continuity of care were processed and operationalized through the eating disorders team. In section 4.5 (part 2), I will present the results of the study, consisting of the emergent themes from the data that I developed into a theoretical model (see Figure 7). In section 4.6 (part 3), I will present the strengths and challenges of the Eating Disorders Program structure in regards to continuity of care, and how the types of continuity of care relate to the healthcare system factors present in the Eating Disorders Program. Figure 7 shows a map of this chapter. appendix 3 contains the full code list and tables of sample code for axial and selective coding.


4.7.2 Health System Factors
4.1 Types of continuity of care
4.2
Informational Continuity
4.3
Management Continuity
4.1.1
Providers
4.4
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4.6
Dimensions
Patient
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Social
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Clinical
4.6.3
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4.6.5
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4.7.1 Program Structure

Figure 7:Theoretical Model – Continuity of Care of a Team-based Eating Disorder Program

4.1 Expanding on Haggerty's Types of Continuity of Care

The results from this study expand upon Haggerty's three types of continuity of care (2003). Through this exploratory study I aimed to better understand how the three types of continuity of care exist and interact with each other. In the context of the Eating Disorder Program, the care providers form a centre from which the different types of continuity of care emanate in a cyclical process (see Figure 8). After the data analysis I was able to understand how the three types of continuity of care were interacting empirically. I found that continuity of care begins with informational continuity: with the team learning with and from the patient and the family. For example, during the one-day assessment of a patient, using an interview and standardized assessment, the team learns about the physical and psychological symptoms that the patient has, and learns about their family situation, such as whether the parents separated or if the patient has siblings. The patient and family also learn about eating disorders or other comorbidities that the patient may have, such as different types of anxiety. Management continuity occurs when all the information is compiled and used to develop a treatment plan that is applied within the program structure. From there, the team can have a consistent approach. The information gathered was also used to develop relational continuity, which involves trust and frequency of contacts between the healthcare providers and the patient and the family. When the patient is close to being discharged from the program informational continuity increases in intensity. For example, the volume of information is more abundant and more details are exchanged within the team, with the family, and with different actors in the community who are

going to be involved in the patient's care after the discharge. This is a period where a lot of information is exchange between the different actors. I would like to emphasize that although each types of continuity of care was observed empirically, the three types of continuity of care are not mutually exclusive because they depend on each other to be effective.

The section above presented the outline of how the team creates the process of continuity of care. In the following sections, I present each type of continuity of care and how they are linked to critical points of care, as well as how they are influenced by different dimensions, which are discussed in Section 4.6

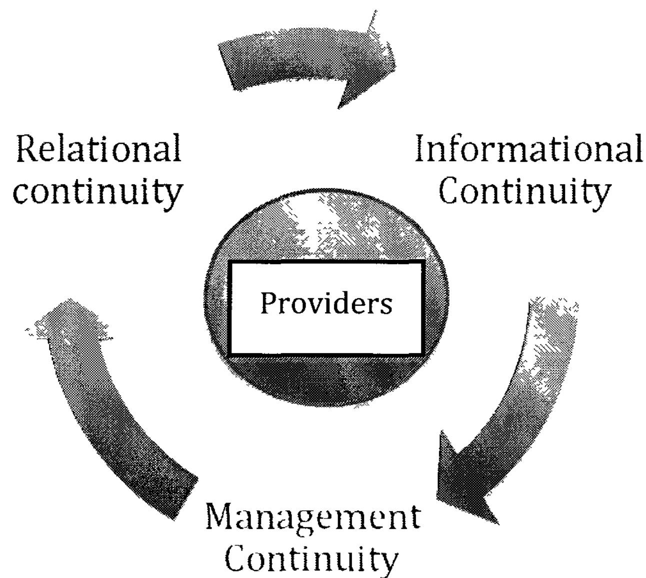

Figure 8: Cycle of continuity of care

4.1.1 Providers and continuity of care

The team members are essential in orchestrating the process of continuity of care; therefore, I gathered data through the interviews to understand more about their perception of continuity of care. This is also why the providers were conceptualized as forming the centre of the circle of continuity of care in the theoretical model (see Figures 7 and 8).

Team members' perception of continuity of care:

> "*I: How do you define continuity of care?*
>
> *R: I think of it as healthcare providers doing their best... it's keeping the care plan and the caregivers as consistent as possible. It's the ability to keep a patient linked to the same care team because that usually leads to better prognosis because you can build better relationships and better trust and hopefully be able to work farther with that patient. There's usually less communication error, less error overall in their care."* DT1 (interview)

It was interesting to note that the definition of continuity of care given by the interviewees was different depending on the type of provider. The child and youth counsellors focused on management continuity; the dieticians and the psychologists focused on relational and management continuity; and the nurse and physician focused on informational continuity in their definitions. When specifically asked, each type of providers was able to describe how each types of continuity of care were experienced in their practice.

4.2 Informational Continuity

Haggerty et al. (2003) defined informational continuity as the use of information on past events and personal circumstances to make current care appropriate for each individual. As

observed during data collection and analysis, the process of informational continuity involves collecting information about the patient and/or family that is relevant to the treatment. In the case of the Eating Disorder Program, the informational continuity process starts when the team receives a referral, usually from a family physician. The triage nurse then calls the family and a first screening is done over the phone. The family then arranges an appointment for a one-day assessment. During the initial one-day assessment, a psychologist, a physician, a dietician, and a psychometrist assess the adolescent and meet with her family. It is mandatory that both parents are present. During that process, the professionals meet at the beginning of the afternoon to receive the summary of the information gathered by the psychometrist. Each professional then performs their own assessment through meeting with the adolescent and the family. At the end of the afternoon the group meets to discuss their findings and determine whether the adolescent fits the criteria for being admitted to the program, whether she needs hospitalization or a follow-up in the outpatient clinic, and by whom would the follow-up be done. Afterwards, the results are discussed with the adolescent and her family as illustrated in the following quotes:

> *"We do full day assessment that includes psychological measures and nutritional assessment and medical assessment, psych interviews. We didn't always have the parent interview piece and so we learned very quickly that that was important. Parents needed to feel involved and there are always multiple perspectives to every situation so it's important to get those perspectives."* PSY3, (interview)

> *"After the assessment is done we all come back at the end of the day and sit as the group of professionals, with the physician, the dietician and the therapist and figure out, okay here's all the results that we got, you know, the medical results, nutritional assessment of what this youth has been eating or not eating. And then*

the mental health piece and looking at, okay what do we think this youth needs to recover, what services do we need to offer them, what are our recommendations for therapy, for medical stabilization and coverage and what do they need in terms of dietician and nutritional education." PSY2 (interview)

Once the patient is admitted to inpatient or day treatment, one of the team members will do a short presentation to the other members of the team. Informational continuity then starts:

"I see continuity of care as preventing gaps in service and transitions should be smooth. So if you've got a patient that's moving from one treatment to another, then we want that transition to be as smooth as possible. So it will involve effective communication, it will involve effective planning, it will involve, appropriate introduction on behalf of the patient. All of those things are kind of absolutely critical. Communication is probably one of the biggest pieces of that and I would say that in almost all cases I think as a team we do that quite well, certainly within our program." MD2 (interview)

The following quote is an example of the type of information shared when the patient is being presented:

"RN1:BMI 14.1, very pale, acne, target for teasing at school. Vitals, bone density, blood work is stable. We will do another assessment on Tuesday." (non participant observation)

And the interprofessional aspect of the team enriches informational continuity:

I don't try to be the psychologist ever, the psychologist doesn't try to be the dietician ever, we highly value each other's kind of position. I think that's something we're quite good at. We really take into account each person's view, as well as the nurse and the CYC (child and youth counsellor) *that spend 12 hours a day around these kids. Their input, and come together to create a plan, but we also, I think, are pretty prepared and aware that the plan will evolve and change and adapt as we go with the kid.* DT1 (interview)

Informational continuity is closely linked to interprofessional collaboration and critical points of care as discussed in the next section.

4.2.1 Informational continuity and critical points of care.

Informational continuity also occurs when the patient transitions from one professional to another and when the patient moves from inpatient to day treatment. In the following example, the transition from one dietician to another one is discussed:

"When I hear about them coming [to day treatment] then I will go to rounds to just hear some of the details, you know. And then (DT1) and I sit down and have a pass over of their documents and a discussion of their progress and any issues and difficulties that they're having. And then, she'll talk, you know, to the parents about me beforehand and I always to try to meet the kids physically, like I'll just once in a while pop into the lounge here and just kind of say hi to the inpatients, just introduce myself so that if I haven't met them before so that in case I'm covering for [Name 4] or they're going to be coming to day program, so they're familiar with the concept that there is a dietician over there too." DT2 (interview)

As mentioned earlier, the three types of continuity of care evolve in a cyclical pattern. The following statement from an interview with one of the medical doctors describes how informational continuity becomes increasingly important as the patient approaches the time for discharge:

> *"A good example would be a patient that we recently transitioned to a day treatment program in Toronto. Now I actually felt that, in terms of continuity of care the transition went really well. So I had the opportunity to contact the medical physician that would be kind of taking over the patient. I gave a verbal kind of handover; I then provided a written summary and faxed that to her attention. Our Dietician made up a very comprehensive dietary handover that was faxed along, and as did the psychiatrist. So from that standpoint the patient had an opportunity to go see the program first, make sure that it was a fit, came back and fed that back to our team, had a chance to meet with her therapist here before she was ultimately transferred, and then they went together as a family. So that was probably best cased transition."* MD2 (interview)

In the context of the Eating Disorder Program, I found that care clearly starts and ends with informational continuity. It is the first step and the last step in the process.

4.3 Management Continuity

Management continuity refers to the management of the healthcare condition in a coherent and consistent manner (Haggerty et al., 2003). In the context of this study, management continuity occurs within a team-based model. The program is structured to address the needs of the patient according to where she is in her recovery. The program is flexible and the person can

enter it at different steps of the program: inpatient, day treatment (usually a returning patient), or outpatient. Each step of the program has a specific objective regarding the management of the eating disorder.

During the inpatient stay, management continuity focuses mainly on medical stabilization. In the following quote, a physician gives a good example of management continuity and how the clinical dimension influences it:

> "*The in-patient program it's probably our most intensive program, and by that I mean patients come in and they stay in hospital 24 hours a day, 7 days a week typically, at least in the beginning. One of the primary goals of the in-patient admission, and again it depends on which population you're looking at. So if we consider a low eight patient with anorexia nervosa, then the re-feeding aspect is a really important part. Again, addressing and dealing with comorbidity is not far behind. So, you know, a lot of these patients, a lot of the patients that get admitted will have either a comorbid mood or anxiety disorder, so it's working with them in that regard*". MD2 (interview)

In the day treatment stage of treatment, management provides a structured program that the patient is required to participate in:

> "*[I]t's a structured program, they automatically participate in all the groups that is set up and the schedule that is set up?*" CYC1 (interview)

The nurse made the following statement regarding the importance of keeping the doors to the program open and to be flexible in order to be responsive to the needs of the patients and their family, which is also part of management continuity.

"[T]he continuity goes from in-patients to day hospital to out-patient services and sometimes it means that there's a failure in out-patient services and they need to re-enter, and they re-enter maybe at day hospital to do a term in day hospital again, back out to out-patient services. This can be explain by the fact that they are not always ready to accept the tools and so we never close our doors, we never say, well we don't see that our services are working, we know that a mental illness is a life-long disorder sometimes, that they need to learn how to function in life with." RN1 (interview)

Management continuity is complex and there is crucial time when it should occur. The following section will discuss it.

4.3.1 Management continuity and critical points of care.

Management continuity occurs once assessment is done and that the care plan is determined as illustrated in the following quote:

"My experience working on this team is we usually do a comprehensive assessment, which has psychological component, medical component, dietician component. All of that happens with the individual and with their family. We come together as a team and debrief on what each of us found, what we think, what direction we're going with. We'll even have a discussion about our gut feeling on this, so we'll kind of hash out what we found, based on our assessment and then set a care plan as a team." DT1 (interview)

Throughout the treatment the primary therapist is in charge of management continuity of care within the team since it is her responsibility to provide the full picture for the team:

"In a lot of ways, their main therapist becomes the point person that will really guide the rest of us on where we need to go, what the goals will be. Physician will also play a huge role but physicians can come on and off of a service and change throughout the patient's care. Their point person psychologist does not. I could change, the dietician role could change between in-patient and day treatment, so the consistent player really is the therapist. All of us, I think, can contribute, can help tailor it, can give our opinions, can say what we think needs to happen. The therapist really does help guide us on where we are going with the patient. The physician also and then we kind of fill in the pieces, I'd say." DT1 (interview)

"If it's a patient that is a part of the intensive treatment program, the therapists are usually the ones that are driving the plan, certainly with kind of close consultation and liaison with the medical physician but the difference being continuity of care. So once a therapist is assigned then that's their therapist, you know, barring unforeseen circumstances, like a maternity leave or something like that." MD2 (interview)

Decisions about management continuity often happen during rounds and are lead by the primary therapist:

"Otherwise we talk a lot in rounds and on the floors about, okay this is what I'm getting, what are you getting? What do you see? This is what I'm seeing. So we talk about what was seen in medical review, what was seen in goals group within the therapeutic milieu's on the floors and then what am I seeing from the family and in individual sessions and putting all of that information together and then

trying to make a decision right in rounds about where we're going. Otherwise we, if it's too big of an issue we go for a case conference in terms of all the players sitting down at the table again. Sometimes with the family, sometimes just us at first, deciding okay, how do we cover all our bases and provide this youth with the most support without... And doing things that aren't harmful because every kid is so unique." PSY2 (interview)

During rounds, critical points are discussed and decisions are made as a team. The goal as a team is to have a democratic approach to the development of the treatment plan:

"Patient J.

DT1: Down 200 grams.

CYC3: In group walk, she can't walk with us, she walks in front. She constantly exercises.

PSY6: The deal is if she can't walk with the group, she can't come so parents are really worried if it might hurt her. I spoke with MD3 about rendering her incapable. If we do that I suspect she increase a lot. We need to have the parents on board give them the option to ask all the questions that they might have." (Non participant observation-Meeting 11)

The clinical complexity of the eating disorders require an interprofessional team, not only for the assessment and the gathering of information, but for the management as well:

"Well I think eating disorder patients are very complicated, they're probably more complicated than most patients in the sense that there are usually significant

psychiatric issues, psychological issues. The eating disorder rarely kind of exists as a primary entity, so there's almost always some level of comorbidity, which again takes expertise. So then you need expertise on not only the eating disorder but you need expertise in the comorbidity as well, whether it be, you know, depression, anxiety, OCD, whatever. But then the other aspect is the medical piece. So you really need to be a fairly well rounded clinician or healthcare provider to be able to kind of tackle all of the potential needs of the patients." MD2 (interview)

"Through rounds, you have expertise from multiple areas. You have psychological, psychiatric, nutritional and medical. So that if there are issues that are coming up with a patient you're able to draw upon somebody that's got specific expertise. If it's a question around re-feeding syndrome then you've got a medical physician that is well versed in the literature, best practice etc., and is able to kind of offer guidance on what we should do next." MD2 (interview)

With certain types of comorbidity, the eating disorder team sometimes has to reach out to other specialists to keep the care consistent and coherent for the patient's changing needs:

"Continuity of care, I think it goes sort of laterally. So within our team and within the hospital, like at one point in time are we covering, are we treating all of the things and covering all of the areas that this youth needs help with? We had a youth who has diabetes so lots of case conferences with endocrine and the diabetes team to make sure that what we're doing is in keeping with what they were doing and were able to understand how our nutrition fits with what they

would recommend nutritionally. So laterally working within our team to make sure we're all on the same page, but also working with whatever other systems need to be worked with, and with the family as well." PSY2 (interview)

Management continuity needs to be constantly readjusted as the patient evolves. This means that frequent meetings are necessary to provide coherent and consistent care in which the primary therapist is the lead.

4.4 Relational Continuity

Relational continuity is defined as the ongoing therapeutic relationship that is developed between one or more healthcare providers (Haggerty et al., 2003). In the case of the Eating Disorders Program, relational continuity is developed with numerous healthcare providers; however, it is the primary therapist, who is either a psychologist or a psychiatrist, who is the most stable person as the patient and the family are transitioning between the different steps of the program. Therapeutic relationship and relational continuity are key elements in the journey to recovery. The clinical psychologist interviewed insisted on the importance of relational continuity of care and how it occurred in the program:

"...[O]nce they become an in-patient they have a dedicated therapist assigned to them within the next couple of days. Then the therapist will sit down and say, I'm going to work with you from here on, working with you through the various services." PSY6 (interview)

"I think with eating disorders, they are so highly emotionally sensitive and at times very concrete. Eating disorders is usually attached with comorbidities and anxiety and OCD, so having something or someone consistent throughout their

progress, being able to build relationships and build bonds with the people is extremely important so that the continuity of care can happen as well as looking just deeper into the layers of continuity of care, being able to build those rapports, being able to identify and offer support through that." CYC3 (interview)

Personality types can also have an impact on relational continuity:

> " *I think it's like anything in life, some personalities mesh and some personalities don't. So if a patient really struggles to connect with a certain caregiver, that would be a con if that's the one that they're left with for in-patient, day treatment, out-patient, long-term care, right? Because if they're not connecting, then they're not building the relationship. So there can be cons if they're not making a good connection with the team".* DT1 (interview)

The therapeutic relationship is very important in mental health. This is especially true for the treatment of an eating disorder because many patients cannot differentiate the illness from their self. Therefore, trust is needed to help the patient in their path toward recovery.

4.4.1 Relational continuity and critical points of care.

Relational continuity also provides a feeling of safety if the patient is readmitted to the program:

> *"So when they come back, if they do need to take a step back they're exposed to the same people. That helps with offering support and that therapeutic relationship is there. So if we're expressing to the patient that we are the care providers that are going to keep them safe, they are not going to let their eating*

disorder overrun their thoughts, we are there to ensure distraction, while keeping that ongoing relationship with the patient allows us to have them keep that open mind and accept our feedback and accept our strategies." CYC3 (interview)

Compared to the other types of continuity of care, relational continuity was harder to link with critical point of care since it is something that was harder to observe during the non participant observation. However, I noted that discharge can be difficult for some patients who are very attached to their primary therapist.

4.5 Interaction of the Different Types of continuity of care

As described earlier in this chapter, I found that the process of continuity of care is circular starting with informational continuity feeding into management continuity. Relational continuity is then developed and finally information continuity re-emerges close to discharge. This section provides examples of how the types of continuity interact with each other in the context of the Eating Disorder Program.

4.5.1 Interaction of informational continuity with management continuity

Informational continuity feeds into management continuity. Management continuity is the consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs (Haggerty et al., 2003). I found that information about the patient/family is frequently gathered by different members of the team. A dietician from the study described in an interview how sharing the information among the different team members then helps to inform the management continuity of care:

"We work very closely together to ensure that we're giving the same message, to children, to the teens and their parents. And that we are caring for the consistent plan, make sure that all team members know exactly what we're doing. And it's, basically I look upon it as the child and the parents, the family, are the most important part of this care." DT2 (interview)

The following discussion between two of the doctors during a team meeting provides an example of how informational continuity leads to management continuity in the context of team meeting:

"MD1: I do think she has body issue but won't admit it because she would fit in the mainstream of society. She started eating less because of chronic stomach pain secondary to anxiety and also out of purity. She is really afraid of institutions being unkind. It is really tricky, I am really worried, with any other kid I would put her on a form but then I would lose her.

MD2: Do you want me to do it?

MD1: It won't matter. Logically it would be better because then I could do a form 3 but we will wait. She is like a kid, she has to be reassured."(Non participant observation-Meeting 3)

Informational continuity leading to management continuity also occurs in the form of informal internal communication between the team members, as described by one of the team psychologist. It emphasizes how keeping the care coherent is important and also responsive to the needs of the patient:

"There's so many people having contact with the youth and we want to keep things the same, that after I have a session with the youth I'll go in to whoever's on the frontline staff and say, so I just had a session, the youth is pretty upset because we talked about this, so can you provide some extra support? Or, so this is what we've talked about and I think this is where we're going and this is how she's feeling or this is the feedback I got from the youth or the family about what happened. And so just giving them sort of up to date information as you can." PSY2 (interview)

4.5.2. Interaction of informational continuity with relational continuity.

Informational continuity also sets the foundation to create relationships that lead to relational continuity:

"I think the way that we work at that is by regular rounds, on Mondays and Thursdays, where each patient and their progress and what's going on is discussed on a variety of levels. We hear about their physical condition and their, how they're doing with the dietician. We hear also about where they're, how they're doing in groups and sort of on the floor with each other. And then we hear from the individual therapist. So everybody on the team gets information about all of the patients involved, and I think that really helps in terms of keeping relationships or transferring relationships from one component of the program to the next." CYC 1 (interview)

The information shared in rounds (informational continuity) facilitates relational continuity.

" I: How does the team make sure that the information from in-patient and the relational, yeah the relationship that is developed, like therapeutic relationship that is developed with an in-patient is continued throughout the three steps basically?

R: I think the way that we work at that is by regular rounds, on Mondays and Thursdays, where each patient and their progress and what's going on is discussed on a variety of levels. We hear about their physical condition and their, how they're doing with the Dietician. We hear also about where they're, how they're doing in groups and sort of on the floor with each other. And then we hear from the individual therapist. So everybody on the team gets information about all of the patients involved, and I think that really helps in terms of keeping relationships or transferring relationships from one component of the program to the next. " CYC1 (interview)

Appropriate management continuity often requires that informational continuity also occur, in order to ensure that key persons are informed and can adequately carry on the treatment plan. For example, the dietician described how sharing information with the patient's family is key to ensuring that the management of care is carried out:

"I don't make any adjustments to a patient's nutrition without family being aware. Weekly I meet with the family to make sure that they understand what the nutrition plans are and nutrition care is, I help educate them on kind of anything that they need to know to help supply, like support their child in their recovery. It means weekly meetings, it means weekly phone calls, talking to them and they have my

phone number and email so if they need to contact me at any point with questions or concerns, absolutely." DT1 (interview)

The primary therapist is the main contact person for the patient and their family during their path to recovery and the transitions between services. This means that it is the primary therapist who orchestrates relational continuity and therefore also leads management continuity.

"Whereas the medical physician can switch out, depending on where they're at in their treatment. So if they're in in-patients then they may be exposed to myself, [Doctor 4] and [Doctor 3] over the course of a two or three month admission. And so for that reason the therapists tend to be the ones that are really driving the bus, if you will." MD2 (interview)

4.5.3. Interaction of management continuity with relational continuity

Management continuity can strengthen relational continuity when the providers, in addition to the primary therapist, witness and support the patient and their family throughout the journey to recovery:

"R: What I like about my position is that I do have an opportunity to be part of, from when they're admitted as in-patients, through to when they discharge from day hospital I really like that.

I: Which is quite similar to the primary therapist?

R: In a lot of ways, yeah. It is really, it's really special, I really like it. I think, the neat thing about that, one of the important things about that is it just adds strength to their recovery to have people who have been, like a witness to their

trajectory and are able to speak to that and to put that into words and narrate that for them, I think is important. And then even after that, like just here and there sort of touching base with out patients and just like that to continue to be someone who they know supports them." PSY3 (interview)

In the transition between services or close to discharge, informational continuity is crucial to either have effective management continuity in the new service or to help the parents in providing effective support at home after discharge.

4.6 Dimensions that Influence Continuity of Care Processes

When analyzing the data, five themes emerged as dimensions that influence the different types of continuity of care. The five themes are: social, clinical, environmental, political and financial. As illustrated in Figure 7, the social, clinical and environmental relate directly to the patient.

4.6.1 The social dimension.

As the data was analyzed, it became apparent that social dimensions played a role in continuity of care. For example, the social interaction of the team members is important to ensure effective team function: knowing each other's roles and trusting the other team members' opinions facilitates collaboration and shared decision making. The social dimension of the team thus influences the team's ability to deliver informational, management, and relational continuity of care.

"So this is definitely, having worked on other teams in other areas, this team is very much, we really rely on each other in our disciplines and stuff. So there's not very many situations, if any where each person doesn't get their input kind of

thing, in my opinion, right. So I don't try to be the psychologist ever, the psychologist doesn't try to be the dietician ever, we highly value each other's kind of position. So I think that's something we're quite good at. But we really take into account each person's view, as well as the nurse and the CYC that spend 12 hours a day around these kids. Their input, and come together to create a plan, but we also, I think, are pretty prepared and aware that that plan will evolve and change and adapt as we go with the kid" DT1 (interview)

When addressing eating disorders with children and youth, another important social dimension the interaction between the team and the family who are an integral part of the treatment:

" I would never see a patient without involving their family, no matter what age that patient was. And then it just depends on the patient and family scenario as to how often I see family, how often I see the patient. But it's primary in my practice." MD1 (interview)

Families are part of the team:

"So the collaboration with the family is working with the parents and the youth and not telling them how things should be done, but coming to an agreement and trying to figure out what's going to work for them, and I think that's the other part of collaboration. And including the family in treatment because for younger youth you can't do it without the family and for older youth they still need the family to fight this illness and to be able to recover." PSY2 (interview)

The social dimension also influences relational continuity and it is put forward when a patient

needs to transfer to another team.

"And then we invited the patient in so she could visually see the team on a video conference, even though they're six hours away. And so she saw the team, she saw us working with the team, in fact her parent, one of her parents was with the team in Sudbury so she saw dad with the therapist in Sudbury and the dietician in Sudbury." PSY4 (interview)

Additionally, the social dimension can have a direct impact on the illness, which is a clinical dimension in the proposed theoretical model:

"CYC2: she went to school and she had symptoms, the trigger was she heard the teacher talking about her diet and losing weight. So I have to talk to her.

PSY6: Out teacher?" (Non participant observation-Meeting 11)

It was observed that the clinical dimensions and the social dimensions are closely linked together since one influence the other and vice versa.

4.6.2 The clinical dimension.

The program structure includes frequent meetings where the team members can exchange information and plan for treatment. Therefore, the clinical dimension is strongly linked to informational and management continuity:

"I think the way that we work at that is by regular rounds, on Mondays and Thursdays, where each patient and their progress and what's going on is discussed on a variety of levels. We hear about their physical condition and how

they're doing with the Dietician. We hear also about where they're, how they're doing in groups and sort of on the floor with each other. And then we hear from the individual therapist. So everybody on the team gets information about all of the patients involved, and I think that really helps in terms of keeping relationships or transferring relationships from one component of the program to the next." CYC1 (interview)

And this is an example of how the clinical dimension is discussed in meetings :

> *"PSY4: 17 years old, we diagnosed her with ..., she's extremely focus on her appearance. General anxiety and signs of PTSD, 2 traumas earlier this year. History of drama with mom. Dad's very committed. He did jail. No history of physical abuse...But minimal restriction. A lot of preoccupation with image. I am going to meet with her next week. (To Md1) she had some question about her bone density and I will give her some resources in the community because she did face a lot."* (Non participant observation-Meeting 12)

The clinical and social dimensions were the dimensions that were addressed the most during the team meetings.

4.6.3 The environmental dimension.

Because the eating disorder program has a provincial mandate, it is common for patients and their family to come from communities located far from the treatment centre. This may require adolescents to be away from their families for several weeks. Also, because of the nature of the disease, the family must be involved in the treatment to improve outcomes. This may require the parents to stop working for a time to be with their child, and also that the other

siblings may not be receiving as much attention. It also means that the outpatient services occur at another healthcare facility and coordination is needed with them at discharge.

> *"I: I saw that some of your patients are not from Ottawa, so that's another challenge I guess, when they are going back to their community?*
>
> *R: It's a huge challenge. Knowing what the services are there and trusting what the services are there, I think that's a challenge, yeah."* CYC1 (interview)

The environmental dimension, in this case the geographical location of the patient and her family, are taken into account when they are doing management continuity:

> *"And another thing that can determine that is geographically what is appropriate. So someone who lives five or six hours away may benefit more from an in-patient stay, a longer in-patient stay, and then go home. Where someone else may benefit exactly from day program and at that point the program offers support to parents to be able to stay here during the 12 weeks in day program."* CYC3 (interview)

The child and youth counsellor goes to provide another example of how the environment influences management continuity:

> *"When the patient is out of town the continuity of care is affected by not being able to be exposed to elements in their community that could be potential triggers and how to manage that. So it is very synthetic in a way that we're asking them to manage in the community where they are not known. So it's almost like, you know, going on vacation somewhere, it really doesn't matter how you act because you're never going to see those people again. So that's really unfortunate and that's why now we're becoming more open to extended passes. So allowing them,*

once we feel that they're able to manage that, allowing them to go back home and come here and check in afterwards. So I think that does help with the continuity of care." CYC3 (interview)

4.6.4 The political dimension.

The political dimension refers to the power structure that exists within the team in terms of the hierarchy among the different healthcare professionals that are working together in the Eating Disorders Program. The tension that arises from this power structure can impact management continuity as well as patient length of stay:

"We have anxieties because we don't know if the call that we're making or decision we're making, if the therapist is actually going to support that when they come back. So we are always very careful and unfortunately sometimes it's frustrating but sometimes the patient's care is basically set to pause until the therapist comes back (from holiday). Which can add up, sometimes two weeks to a patient's admission, when they could have maybe been integrated back into the community or integrated into a new program or day program by then." CYC3 (interview)

Another example:

"And I think also there at times might be a hierarchy that gets established although it may not be said, there is at times a feeling of hierarchy because of communication barriers or, communication is not missed. Therapists may make a treatment plan and then expect frontline to follow it, whereas frontline had been discussing (something else). I'm just giving you an example, like where frontline

would be discussing different care plan ideas but none of it would be addressed and something else would be decided without frontline knowing. And then frontline is just simply expected to follow through and not have any opinions on that. That can be extremely difficult and disempowering. So I would just say for continuity of care the team dynamics could sometimes be much improved." CYC3 (interview)

Although the team wishes to have democratic decision-making, it seems to be challenging as illustrated by the previous quotes.

4.6.5 The financial dimension.

The financial dimension impacts how the program functions and how continuity of care occurs because it influences who can access the program:

"Specifically we're funded for the 13 to 18 year olds." PSY3 (interview)

The financial dimension also influence how human resources are attributed:

"So in the evenings, due to sort of the current situation in our funding, we've sort of had to adapt and improvise and I've been lending support in the evenings and acting as kind of a frontline therapist in the evenings" PSY3 (interview)

The way the physicians are remunerated allows them to assist in the team meetings and therefore has an impact on informational and management continuity:

"R: No, I'm on a salary.

I: You're on salary, okay, that's what I was wondering.

R: I would starve, there's no way you could do this job as a fee for service patient because of the amount of time that you spend kind of in rounds." MD2 (interview)

The financial dimension also impacts continuity of care in the outpatient service since many of the therapists in the community have private practices.

"I do think people, if they fall through the cracks it's because, you know, for the most part one of the other challenges is just finding a therapist that has the training and in some cases finding the funding for those clinicians in the community". PSY4 (interview)

The five dimensions emerged during axial coding and many open codes were conceptually linked to each of them. The more prominent ones were the social and clinical dimensions. It is on these dimensions that the team members were focusing the most during their meeting. I would argue that it is on these dimensions that the team can have to most impact during treatment and the process of continuity of care. It was harder for them to be able to modify the environmental dimension, they had to adapt to it in providing continuity of care. As for the political and the financial dimensions they definitely have an impact on the process of continuity of care, however they are more implicit and it is harder for the team members to have an impact in them.

4.7 Barriers and Facilitators.

The process of continuity of care is complex and can be challenging when it involves many actors from different perspectives and disciplines. We can find these challenges in relation to the different types of continuity. The following section will discuss barriers and facilitators to

continuity of care, first in the Eating Disorders Program (4.7.1) and then in the different levels of the healthcare system (section 4.7.2).

4.7.1 Eating Disorders Program structure.

Barriers to informational continuity

Informational continuity between the parents of the patient and the team can be challenging after the patient has been away from the treatment centre for a weekend passes, when the patient has been spending time alone with her parents and is going back to continue her treatment with the team. It is very important for the team to know how the weekend was to understand how the patient is evolving outside the hospital, and if there are difficulties that need to be addressed during therapy. This challenge can be found in day treatment and inpatient treatment:

> *"R: We really encourage parents to call us on Sunday evening to give us a, you know, their view on what the weekend was like and how it went. And if at any point in the process we run into snags, like challenges, we try to include the parents in resolving them.*
>
> *I: I heard you say yesterday during the meeting that the Sunday report can be challenging sometime, like parents not calling?*
>
> *R: Yeah; not many of them are. So most weeks I will hear from two, maybe three parents, but there are seven or six kids in the program, so you know. At this point I haven't called family to get their input, the onus is sort of on them, you know. And that's probably something that I should further discuss at rounds, whether*

that's a step that I should take or not. My understanding so far is that the onus is with the family. CYC1 (interview)

Interviewees mentioned several times that informational continuity could be improved in outpatient services because they currently do not have a formal way of communicating in inpatient and day treatment services like they do with team meetings (rounds):

"Well we don't have rounds on clinic out-patients. When there is an out-patient that's in crisis, their name will get put on the board, we'll discuss them. But otherwise, I know myself and some of the physicians have kind of sat around and been like... We don't have a formal time where we sit down with even their therapist and make sure we're all on the same page once they're coming weekly to clinic. If I do something really big with a patient I'll call the therapist and leave them a message, but it's not anything formal." DT1 (interview)

Barriers to management continuity

The challenges of internal communication can impact management continuity of care and create tension between different team members. Ineffective internal communication can also impact the support that is needed between the different team members.

"R: I think at times there can be communication barriers or communication issues between the team. It can be extremely difficult for frontline staff to be exposed to such long hours and for so long with these patients, projection and transference happens a lot. And not really feeling comfortable at times to seek

that support from other team members and only seeking it from, with inside frontline can be extremely difficult.

And I think also there at times might be a hierarchy that gets established although it may not be said, there is at times a feeling of hierarchy where, because of communication barriers or, communication is not missed. You know, therapists may make a treatment plan and then expect frontline to follow it, whereas frontline had been discussing... I'm just giving you an example, like where frontline would be discussing, you know, different care plan ideas but none of it would be addressed and something else would be decided without frontline knowing. And then frontline is just simply expected to follow through and not have any opinions on that. That can be extremely difficult and disempowering. So I would just say for continuity of care the team dynamics could sometimes be much improved." CYC3 (interview)

Management continuity in the context of the outpatient clinic also requires that care providers maintain contact with the patient and their family as they evolve through their developmental stages.

"*The out-patient clinic, so important because the chronicity of the illness, you want to offer support as needed and maintain that contact to provide intervention as quickly as possible so things don't escalate. And also to continue, you know, when you think about the stages of change, like the kids are, you know, still in the process of change, and their families too and needing to continue to provide some support around those stages, the later changes of changing*" PSY3, (interview)

Barriers to relational continuity

Vacation and coverage can have an impact on relational continuity since the primary therapist is going away, important decision regarding care is often put on hold until its return. This impact particularly inpatient and day treatment.

> *"Summer time is challenging because there's the whole piece of people taking vacations and that. I think the team has done really well; the therapist component does well in terms of providing coverage for each other.* CYC1 (interview)

Facilitators of continuity of care in the Eating Disorder Program

The interviewees noted several times that one of the strengths of the program was that the same team was in charge of each area of the program (inpatient, outpatient, and day treatment). :

> *"Well I think because it is one team in the three spots, that's what creates that consistent approach. And I think that is very unique here, I've not seen it in eating disorder programs anywhere else, and I hope that we can maintain it. It's harder as a program grows to be able to maintain that. So yeah, so that's, that happens because we keep the same people on the three sites. So it's an ongoing formulation in terms of understanding the patient, again no matter what level of care."* MD1 (interview)

> *"I think the major strength is that it's the same people in each of the areas. Because I've worked in bigger systems in Toronto where it's different teams in the three areas and teams in and of themselves develop cultures and differences. So it develops, it becomes quite disruptive for the patient to move from one to another. Not that anyone's doing anything wrong but what naturally happens. So I think*

the, what I love working here and the biggest strength is that it's the same people and therefore the same philosophy. And therefore it's not of an advantage for the patient to go back to in-patients because they get to see so and so or work with so and so again, they get to work with them no matter where they're at, which allows them actually to recover. Especially kids who may end up sort of playing one person against another." MD1 (interview)

Since the demand is increasing to access the Eating Disorder Program and that the waiting list is long. It is going to be challenging to keep the same team in each of the services (inpatient, day treatment and outpatient).

4.7.2 Healthcare system factors

Through the data analysis, I identified the challenges of continuity of care at the micro (individual), meso (organisational), and macro (system) level.

Micro-level challenges

Hierarchy among the healthcare team members can impact internal communication and management continuity of care. It can create tension between different team members. It can also impact the support that is needed between the different team members in such a working environment.

"R: I think at times there can be communication barriers or communication issues between the team. It can be extremely difficult for frontline staff to be exposed to such long hours and for so long with these patients, projection and transference happens a lot. And not really feeling comfortable at times to seek

that support from other team members and only seeking it from, with inside frontline can be extremely difficult.

And I think also there at times might be a hierarchy that gets established although it may not be said, there is at times a feeling of hierarchy where, because of communication barriers or, communication is not missed. You know, therapists may make a treatment plan and then expect frontline to follow it, whereas frontline had been discussing... I'm just giving you an example, like where frontline would be discussing, you know, different care plan ideas but none of it would be addressed and something else would be decided without frontline knowing. And then frontline is just simply expected to follow through and not have any opinions on that. That can be extremely difficult and disempowering. So I would just say for continuity of care the team dynamics could sometimes be much improved." CYC3 (interview)

Relational continuity needs to be balanced with the reality of the healthcare system, which means that long therapeutic relationships will have an impact on the waiting list. In other words, a new patient cannot be admitted until an existing patient exits the system. One of the doctors interviewed described the impact of relational continuity of care on the healthcare system as follows:

"If I pick up a 14 year old, that relationship is maintained until they're 18. Now that being said, we're trying to shift to only working with them for up to 18 months because maintaining the continuity means that we develop long waiting lists. So that is a major challenge. But ideally, no matter what, that relationship

is continued and their relationship with their medical physician is continued, except that now rotates between three people. So that can be a bit tricky but that needs to happen in order for them to maintain sanity." MD1 (interview)

In terms of team functioning, the need to better understand the role of the other members of the team was identified.

" So frontline staff essentially is, to me, we are the ones that are with the patient the most, we are exposed to different sides of the patient and we report that back to the other members of the team. What the problem I think is right now is I don't think people identify exactly with the role with frontline staff, you know, exactly what frontline staff exactly do. And I think we all need to actually get more training with regards to everybody's role because even with discussing with other team members that are not frontline, I had no idea that they were going through these things, and they had no idea vice versa. So I think that's something that we all as a team need to start working towards too." CYC3 (interview)

Knowing the role and responsibilities of the other team members is important since it improves collaboration.

Meso-level challenges

Frontline staffs face the challenge of under-staffing, which has a great impact on their schedule and personal lives. One of the child and youth counsellors clearly describes it in the following quote:

"So we have days and evenings, so 7 to 3 and 3 to 11. The thing is, because we don't have a big enough team, full time staffs actually have a schedule that is

actually really not appropriate for the level and capacity of the program. Within a 10-day span we work 8 of those 10 days, so there's not a lot of time to debrief or have self-care, so it's very, very difficult for frontlines to re-centre themselves and have that support in their personal life. So that's something that we're trying to push to change but I've been with the team now for a year and a half and it's been a year and a half since we're trying to change that. That's budget and stuff so that's not going to..." CYC3 (interview)

At the organizational level, external communication was identified as a challenge, especially with the therapists in the community.

Because we (the therapists) only see the kids that need either day program or hospitalization, the continuity into the community suffers a little bit. And the way it's set up is that they don't need to see a therapist here, they still see one of the medical physicians here in out-patient clinic, so then that person's working with someone in the community, that communication can get tricky and therefore it's not as seamless as it would be, ideally it could be. But we don't have a team of people working in the community, so I'd say that's an area of weakness." MD1 (interview)

Another example:

"And sometimes it's a little bit more difficult though when you have community therapists that are involved with patients, that may be seeing patients regularly or they may not be seeing patients regularly. I find it difficult sometimes to liaise with them. So in terms of, having to make another phone call, one time out of ten

maybe I'll get them when I phone them, often I'm leaving messages or, you know, often, almost always I'm leaving messages and having them try and kind of contact me. Very infrequently are they able to get me when they call back and so it's often this kind of huge charade of telephone tag, which will often result in us touching base but it may be after a week or two. You know, so if you do that over and over again, typically the lines of communication tend to kind of get further and further apart." MD2 (interview)

Healthcare professionals emphasized that having core values in the Eating Disorder Program help reinforce continuity of care:

> *So I think there's, all of our programs have the same core values, which I think provides continuity. And because we're in so much contact with one another we often, you get to understand why, when [Name 6] says things one way, I know what he's saying and so if the youth comes in and argues I can kind of say, well I think we need to sit down and talk with [Name 6] about this, but also I'm wondering maybe if [Name 6] meant this, because I don't know if he would have said that. But let's go check with him, right. So it's not, I'm not going to say, no I think you're lying to the youth or you misunderstood that but I'm also not going to say, well [Name 6] is wrong."* PSY2 (interview)

Macro-level challenges

The system requires that once a patient turns 18, he or she must be transferred to adult services. It is interesting that it is a policy at the system level but it can be addressed at the organizational and professional level.

"One of the gaps usually within mental health services and most medical services is that transition from adolescence to adulthood, adult services. So one of the things that recently we've started implementing is meeting with the eating disorder program folks over there and having sometimes a nurse over there come here, introduce herself to a 17 year old about to turn 18, to sometimes give them a tour of the program over there. So I think that's one thing that we've tried to address." RN3 (interview)

Another example :

"The one that we're trying to work on a bit better is moving from the children, like the adolescent program to adult program. So right now we're working with the General to sort of know what their treatment is and for them to know what our treatment is so that we can better prepare kids going into the adult treatment program, 'cause it's very different. So up until now it hasn't been seamless and it's not seamless yet to be honest but I think we're getting a better understanding of what the adult treatment offers. And they're getting a better understanding of what we offer." RN3 (interview)

It is interesting to note that the Eating Disorder Program is aware of the difficulties that the healthcare system structure might create and that they are developing mean to make it easier for the patient.

4.8 Summary

The continuity of care process is very complex and is influenced by a variety of elements. In the case of the Eating Disorders Program:

- Continuity of care is defined differently depending on the type of providers.
- Continuity of care seems to operate in a circular fashion.
- Five dimensions influence continuity of care: social, clinical, environmental, political and financial.
- The main dimensions that are addressed by the team are the social and clinical dimensions.
- Each type of continuity of care is associated with critical points of care.
- Barriers and facilitators to continuity of care were identified in link with the structure of the program and factors present in the healthcare system.

Chapter 5-Discussion

In this chapter, I will provide a summary and discussion of the results, limitations of the study, and possibilities for future research.

5.1 Implications of Results

Through the literature review, a knowledge gap was identified regarding how continuity of care is conceptualized and operationalized (Table 1, p.26). More specifically, there is a gap in knowledge of how the process of continuity of care occurs in a team-based context, and how to optimize patient transfer from one team to another. Additionally, the lack of understanding of the process of continuity of care makes it difficult to measure, and therefore it is difficult to assess its impact on health outcomes. In other words, continuity of care needs to be understood as a process closely linked to integrated care to improve quality of care in terms of efficiency, access, effectiveness, and patient satisfaction (Gröne et al., 2002 as cited in Wierdsma, 2009). In this thesis I set out the following objectives:

- To understand how the types of continuity of care- relational, management and informational- as described theoretically by Haggerty et al. (2003)- are interacting during the process of care.
- To explain how continuity of care functions and unfolds in a real-life setting for example at critical point of care like during discharge.
- To develop a theoretical model that explains how healthcare teams are operationalizing continuity of care in the context of women's mental health.

In the following sections, I discuss the process of continuity of care in a team-based context, I explain the meta-model for studying continuity of care, and I provide recommendation for the participating healthcare team. Finally, I present the limitations of the study and the next steps for future research.

5.1.1 The process of continuity of care in a team-based context.

Wierdsma (2009, p.52) underlined the fact that "in order to improve continuity of care, better understanding is needed of the complex inter-relationship of core elements and types of continuity." Indeed, in the context of this study, I validated the existence of the continuity of care concepts identified by Haggerty et al. (2003) (relational, management and informational continuity of care), and I found that they operate in a cyclical process. Existing literature had the three types of continuity of care conceptualized individually, however, it was not described how they were functioning and interacting in a real-life setting. The results of the study showed the Eating Disorder Program used a cyclical approach with continuity of care starting with informational continuity (gathering as much relevant information as possible about the patient and their family), which then fed into management continuity (the relevant information gathered is used to set the treatment plan in place). Once the treatment plan is in place, relational continuity was developed with the trust and sharing that is created with the therapeutic relationships with the team. Once the patient is close to being discharged, the focus returns to informational continuity when the healthcare professionals exchange information among themselves, the patient and family members, as well as external stakeholders.

The cyclical process observed enriches the hierarchical perspective proposed by Saultz, implying that continuity of care starts with an organized collection of medical and social

information, then the care should be assumed by an organized team, and then there is an ongoing relationship between the patient and the healthcare professionals (Saultz, 2003). Once again, similar to Haggerty's study (2003), the hierarchical perspective developed by Saultz (2003) was developed through a systematic literature review and not tested empirically. I think the cyclical process emerges because the Eating Disorder Program aims to offer integrated and seamless care, and informational continuity increases in intensity close to discharge so that the individuals who are going to take over care, whether that is the parent or other healthcare professionals, has all the information needed to carry on efficiently. More studies are needed to establish if continuity of care is hierarchical or not. I would argue that continuity of care is hierarchical in a traditional setting like acute care. However, in a context of an outreach service in mental health with a marginalized population I believe that relational continuity occurs first because the providers first need to build trust with the individual before being able to gain information and provide services.

Through the research I also found that the types of continuity of care are also related to critical points on the care pathway. Informational continuity is closely linked to the process of assessment and admission. Management continuity and relational continuity are closely linked to the development and implementation of the treatment plan. Finally, informational continuity is closely linked to transition between services and discharge. Interestingly, from the definition given by the providers regarding continuity of care, it appears that different providers are focusing on different types of continuity of care. Therefore, child and youth counsellors appear to be more involved in management continuity, the dieticians with management and relational continuity, the psychologists with relational and management continuity, and the physicians and nurses with informational continuity.

5.1.2 A Meta-Model for studying continuity of care.

The theoretical model (Figure 7, p.43) that emerged from the data analysis can be used as a meta-model to study continuity of care because it underlines when each type of continuity of care are operationalized and by whom. I also found that each type of continuity was associated with critical points of care like admission, treatment plan and discharge, where continuity of care is essential. The theoretical model also includes five dimensions that influence continuity of care: social, clinical, environmental, political, and financial. The social and clinical dimensions were prominent during the team meeting. The identification of the dimensions is a first step towards the need to better understands the complex inter-relationship of the core elements and types of continuity as mentioned by Wierdsma et al. (2009). Through two literature reviews of continuity of mental healthcare (Johnson et al., 1997; Adair et al., 2003), it was determined that the operational definitions of continuity of care have remained relatively one-dimensional and discharged based. The five dimensions that emerged from the data allow for a global understanding of continuity of care throughout the whole continuum of health service delivery in the context of the Eating Disorder Program. It was noted that further studies are needed to adequately measure continuity of care and that they should include outcome measures, cost analyses, and information about the local healthcare system and its functioning as a whole (Adair et al., 2003). The dimensions (social, clinical, environmental, political, and financial) could become the basis on which to develop indicators to assess the process of continuity of care. The eventual monitoring of increasingly complex patterns of care will provide information to evaluate changes in service use (Sytema et al., 1989). This could be useful since the demand on the Eating Disorder Program is increasing especially in the outpatient service.

5.2 Recommendations

It was identified through the data analysis that the Eating Disorder Program aimed at offering team-based continuity of care could benefit from improvement in some areas. Challenges were identified in informational, management, and relational continuity as well as at the micro, meso, and macro level of the healthcare system. In the following section, I will recommend some actions that could improve continuity of care in these different areas.

5.2.1 Improvement of the informational continuity in the outpatient service.

As underscored during the interviews there is a need to improve the informational continuity in the outpatient service. The team is accustomed to having a formal way to discuss patients in inpatient and day treatment meetings. However, the quantity of patients in outpatient services makes it impractical to meet on a regular basis. The current work-around is that if an outpatient needs to be discussed, their name is put on the board and discussed at the end of the inpatient or day treatment meeting. However, because it was an information challenge that was highlighted many times, the work-around seems to be insufficient. To address the need for a formal way to discuss outpatients, I would suggest that a group of healthcare professionals involved in the outpatient services could identify the situations that require formal informational continuity. The team could decide as a group if it is better to exchange their information after or before the scheduled clinic, and which format to use, (for example, brief face-to-face meeting, email, or chat forum).

5.2.2 Reinforcing the shared decision-making among the team members.

Through the interviews, it was also identified that there is a need to reinforce the shared decision-making process among the team members. The majority of the team members were

comfortable with the way treatment plan decisions or management continuity occurred, experiencing it as a democratic process. However, it was noted that unilateral decision-making also occurred, and this created frustration for frontline staff. Trust and respect are key elements of interprofessional interaction and means could be explored with the members of the team to see what makes them feel valued by the team and to repeat the success story. It would be interesting to also try this method with patient and family members. This could be an occasion for the team members to learn about each other's role and responsibility as this was identify as a need by team members.

5.2.3 Managing the growth of the Eating Disorder Program team.

Over the year, the Eating Disorder Program team has been growing. At the moment, the size of the team allows the same team members to attend inpatient and day treatment team meeting, where a lot of informational continuity and decisions regarding management continuity occur. Some members of the team did work in a larger eating disorder program in which one team was in charge of the inpatient services, one team was in charge of the day treatment, and one team was in charge of the outpatient services. It was noted, during the interview process, that with such a model, transition was more difficult and continuity was affected. If the Eating Disorder Program team that I studied eventually needs to increase in size to answer the demand, one way that this could be done is to have one team per service (scenario 1 in Figure 9), two teams could be in charge of all the sections of the program, inpatient, day treatment, and outpatient services (scenario 2 in Figure 9). Thus, the caseload would be split in two (see Figure 9).

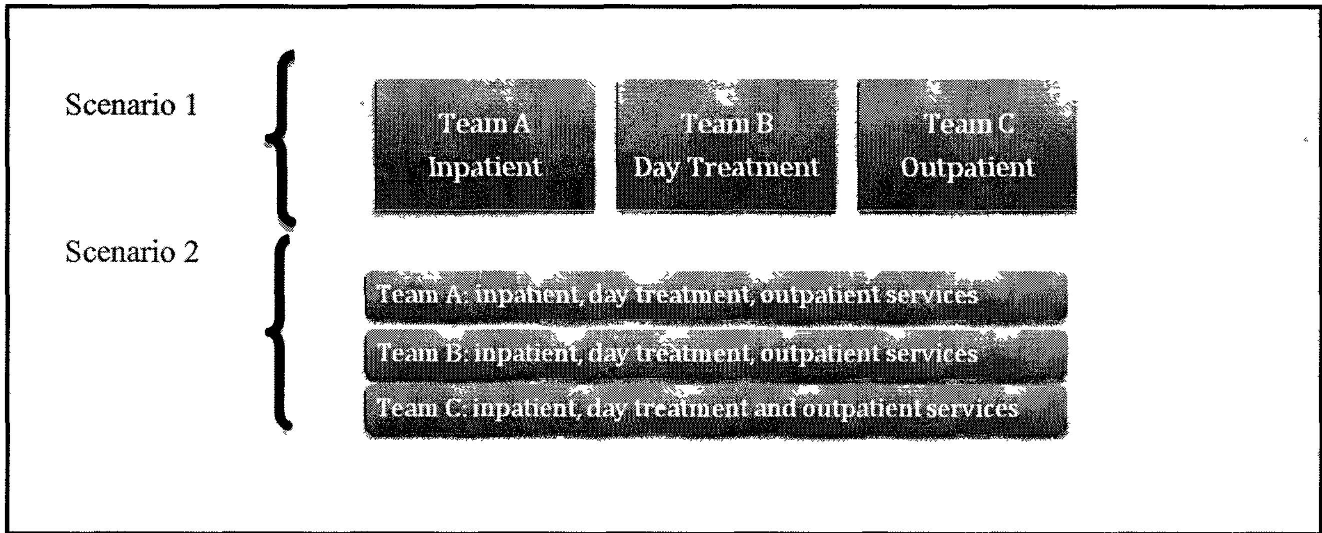

Figure 9: Visual representation of teams

Scenario 2 would also fit within the recommendation that in mental health, care is provided by as few professionals as possible because the patient would stay in the same team as he or she progresses through the different services (Freeman et al., 2002).

5.2.4 Improve communication and informational continuity with community therapists and healthcare professionals in the community.

The challenges of communicating with other healthcare professionals in the community were identified through data analysis. As presented in the literature review, D'Amour et al. (2008) developed four dimensions that promote interorganizational collaboration: 1) shared vision and goal, 2) internalization, 3) formalization and, 4) governance. Dimension 1, 2 and 3 could be reinforced by creating connections between the healthcare professionals in the Eating Disorder Program and the healthcare professionals in the community. The Eating Disorder Program could develop outreach activities to improve their relationships in the community. This could be done through lunch and learn activities or through knowledge exchange activities like an

e-newsletter as suggested by the director of the Eating Disorder Program. This could help develop shared goals and vision, internalize the fact that the healthcare professionals need each other to offer effective continuity of care and to come up with means to formalize knowledge exchange and referrals. It could also help to reinforce the prevention activities.

Finally, this research project demonstrates the need to have policies that are flexible in order to adapt to the specific contexts within which they exist. Policy development is based on standardization and often assumes policy implementation is black and white. As this project showed healthcare delivery is often closer to shades of gray than black and white.

5.3 Limitations of the study

A limitation of the study is found in the absence of the patient and family perspective on continuity of care. Ultimately they are the one who are experiencing the care. Therefore, the theoretical model that was developed with this study would have been more complete if it integrated the patient and family perspective. The integration of the patient and family perspective was considered beyond the scope of a master thesis.

Additionally, gender issue was not apparent in the data analysis, probably because of the gender dominance in the healthcare team and in the patient population. In both cases, the majority of the patients were women. It might have been beneficial to undertake a gender-based analysis in a more gender variable environment.

Finally, I conducted my study on a very specialized team in a tertiary care hospital. As described in the literature review, the healthcare system includes a huge variety of healthcare team and it may be the case that some of the findings highlighted here are difficult to transfer to

other setting. The conceptual findings of a circular nature to continuity of care between informational, management and relational – are testable propositions in future research.

5.4 Future Research: Next Steps

Using the theoretical model that I developed, it is now possible to add to the construct of continuity of care and build on the five dimensions to better understand the inter-related levels. As underscored by Wierdsma the "ongoing confusion about the concept of continuity of care will inevitably lead to mixed research results, and to loss of opportunities to improve the healthcare system. The literature suggests that there are at least two major reasons for this laborious development of continuity of care research: continuity is a difficult construct with inter-related levels, and there are few standard measures used in longitudinal data analyses."(Wierdsma, 2009 p.55). To strengthen the theoretical model, the same methodology could be applied in other mental health services to augment the findings from my research.

An important perspective that needs to be added in future research regarding the conceptualization of the process of continuity of care is the patient and family perspective. One way that it could be done is to do a series of interviews with patient and family members during the same time that the meetings are observed to explore similarities and differences between the team and the patient and family members.

The results of the study also have to be put in a format that is accessible for the knowledge to be disseminated to the participants. As stated by Goering et al. (2008) the goal of this qualitative research was to draw on practitioners' intuition and experience, so it can generate findings that are meaningful and useful to them. As mentioned earlier, this will likely happened in the form of a newsletter and I will be available to answer questions.

Chapter 6-Conclusion

By conducting this research and building the theoretical model, my hope is that this research will add significantly to the already existing knowledge on continuity of care in mental health services by providing additional elements to understand the process of continuity of care. This research also demonstrates that the three types of continuity of care do exist in the clinical environment, that they are three separate entities functioning together and that it is just not a theoretical concept. This research illustrates and explains how the three types of continuity of care identified by Haggerty et al. (2003)—relational, management and informational—were interacting with each other during team-based processes. The five dimensions that emerged from the study—clinical, social, environmental, political and financial—once triangulated with other health services, could become the basis for a more efficient way to assess continuity of care. Finally, through this research, continuity of care challenges were highlighted and recommendations to improve the process will be shared with the Eating Disorder Program team.

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Appendix 1

Detailed Literature Search Strategy

PubMed searches included the following combination of MeSH terms: ("Continuity of Patient Care"[Mesh] OR "Comprehensive Healthcare"[Mesh:noexp] OR "Case Management"[Mesh] OR "Patient-Centered Care"[Mesh] OR "Advance Care Planning"[Mesh] OR "Patient Care Management"[Mesh:noexp] OR "Disease Management"[Mesh]) AND ("Interprofessional Relations"[Mesh:noexp] OR "Patient Care Team"[Mesh]) AND ("Women"[Mesh] OR "Women's Health Services"[Mesh] OR "Women's Health"[Mesh] OR "Women's Rights"[Mesh]). This search produced twelve results, nine were in English and only one seemed relevant from reading the abstracts, and after reading the article I decided not to include it since it addressed women's health in primary care. I looked at the list of articles that related to the relevant one and I found another one. Additionally, I did a combined search in PsycINFO, Embase and HealthStar with the following MeSH terms: Human females or mental health AND continuum of care AND integrated services or interdisciplinary treatment approach AND eating disorder. All three databases returned zero results on these search terms. When I combined "continuum of care AND integrated services or interdisciplinary treatment approach AND eating disorder", I received one hit in PsycINFO that I kept.

I searched the AMED (1985-2008), Medline (1960-2008), HealthSTAR (1999-2008), Embase (1980-2008), PsycINFO, Cochrane Library, and Web of Science databases using the following individual keyword searches: "continuity of care", "healthcare team", "communication", and "women's health". I included peer-reviewed journals and both the French and English language in the search criteria. The search on "continuity of care" returned a large number of articles, so I screened the results using the title of the articles. The title had to imply a

team perspective or a patient perspective. I also screened the results for the searches on "healthcare team" and "communication" to ensure the articles mentioned communication between two different healthcare providers

Appendix 2

Interview Protocol with Healthcare Providers in Mental Health

Hello my name is Anne Brasset Latulippe. I am a master student in Health System and I am interested in the process of continuity of care, more precisely regarding how healthcare professionals are addressing women's mental health issues using collaborative patient centered care. Provide some details about the question areas and approximately how long the interview will take. Also be sure to ask if it is okay if you tape record the interview. Ask if they have any questions before beginning.

Demographic Information

1. What is the purpose of the program?
   a. Purpose of each section?

2. What is the clientele that you mostly serve?

3. Could you please tell me the name of your profession and what is your role in the program?

4. For how long have you been working with this clientele, in this particular program?

Collaborative Care

5. How would you describe collaborative family centered care?

6. What is your opinion about it?

7. How do you think it applies to your practice?

8. Could you please give a concrete example?

9. How would you describe the process of deciding the appropriate treatment for the patient?

a. Probe: who else is involved?

- consult with others

- consult with the client/family, if so what is the process?

10. What are the criteria to transition from one section to another?

<u>Continuity of Care</u>

11. · How would you define continuity of care ?

12. Could you please give a concrete example in your practice ?

13. Difference between team continuity and single professional continuity?

14. What is different about ED that requires continuity of care?

15. What are the strength of the ED program in terms of continuity of care?

16. What are the weakness of the ED program in terms of continuity of care?

17. In the literature we find three types of continuity of care

- The first one is relational continuity and the definition is "the on going therapeutic relationship between the patient and one or more providers". How do you use it in your practice? Could you give a concrete example?

- The second is managerial continuity and the definition is: the consistent and coherent approach to the management of a health condition that is responsive to patient's changing needs". How do you use it in your practice? Could you give a concrete example?

- The third is informational continuity which is the "use of information on past events and personal circumstances to make current care appropriate." How do you use it in your practice? Could you give a concrete example?

18. My understanding is that the patient as a primary therapist and this is how most of the continuity of care through the different steps of the program is happening. Any thoughts on that?

19. Is there any issues regarding continuity of care in a period that many people go on holiday like right now

20. Is there a question that I did not ask you that you thibk might help me understand how continuity of care is happening in your program?

If I need clarifications regarding your answers, could I contact you again?

Thank you very much for your participation. I greatly appreciate

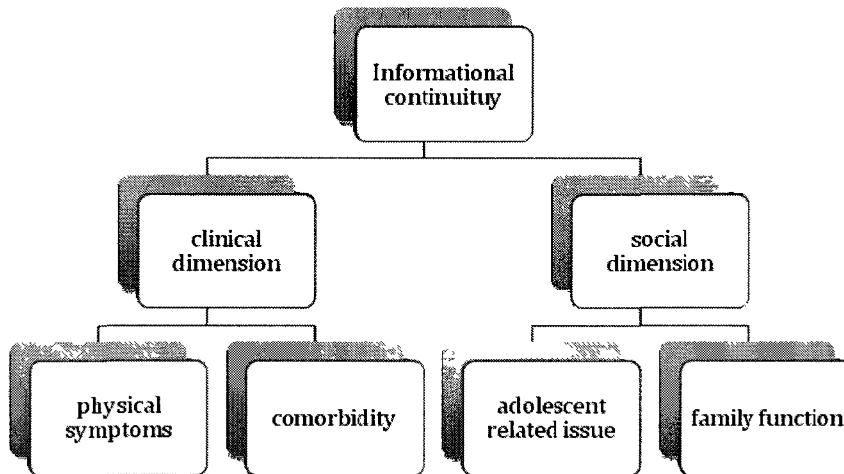
Appendix 3

Data Analysis

Open Code list- initial concepts and categories

Absence
Admission process
Adolescent related issue
Affective symptoms
Age appropriate
Agreement
Assessment
Behavioural goals
Canadian best practice guidelines
Canadian standard of care
Case manager
Challenges
Clinical dimension
co morbidity
Consultation
Continuity of care
CYC
Day treatment
Day treatment goal
Decision-making
Definition
Democratic
Diagnostic
Dietician
Different schedule
Discharge
Distortions
Eating Disorder Association of Canada
ED expertise
Education
Environmental dimension
ER
External communication
Family centred care
Family function
Family support
Financial challenge
Financial dimension
Flexible
Frontline
Funding model
Gender
Goal
Groups
Handover process
Hierarchy
Holiday
Human resources
Informational continuity
Initial assessment
Inpatient
Inpatient coverage
Inpatient goal
Internal communication
Interview
Investigations
Lead
Management continuity
Medical issue
Medications
Network
Nurse
Nutritional goals
Outpatient clinic
Overlap
Parental input
Pathway of patient
Patient management
Physical symptoms
Physician
Planification
Political dimension
Preventing gaps
Prevention
Problem solving
Professional involved
Program management
Program structure
Provincial site and program
Psychiatrist
Psychological testing
Psychologist
Purpose
Recovery process
Relational continuity
Research
Resources
Respect
Role
Rounds
School
Shared decision making
Size
Social dimension
Spectrum of recovery
Splitting
Steps of the program-level of support
Strength
Symptoms
Team functioning
Testing
Therapist
Therapist in the community
Time challenge
Transfer
Transition
Treat psychological issue
Treatment course
Treatment plan
Treatment recommendation
USA
Voice concern
Work experience

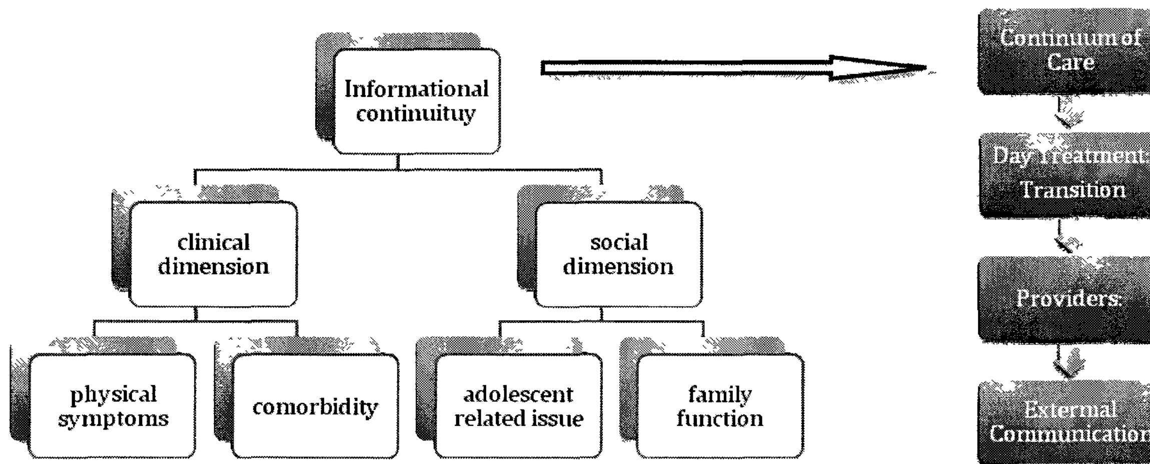
Example of axial coding- revised concepts and categories



Data Source	Data	Open Coding	Axial Coding
NPO-meeting 11	CYC3: In-group walk, she can't walk with us, she walks in front. She constantly exercises. PSY6: The deal is if she can't walk with the group, she can't come so parents are really worried if it might hurt her. I spoke with MD3 about rendering her incapable. If we do that I suspect she increase a lot. We need to have the parents on board give them the option to ask all the questions that they might have.	Parental input Physical symptoms Group	Informational continuity Clinical dimension Social dimension

Example of Selective coding- Final Concept.

Linking the subcategories of axial coding to the continuum of care in the Eating disorder program:



Data Source	Data	Open Coding	Axial Coding	Selective Coding
MD2	A good example would be a patient that we recently transitioned to a day treatment program in Toronto. Now I actually felt that that continuity of care went really well. So I had the opportunity to contact the medical physician that would be kind the patient. I gave a verbal kind of handover; I then provided a written summary and faxed that to her attention. Our Dietician, made up a very comprehensive dietary handover that was faxed along, and as did the psychiatrist. So from that standpoint the	Transition Physician Dietician Written summary Family	Environmental dimension Informational continuity Social dimension	Information continuity Day treatment Providers External communication

Data Source	Data	Open Coding	Axial Coding	Selective Coding
	patient had an opportunity to go see the program first, make sure that it was a fit, came back, fed that back to our team, had a chance to meet with her therapist here before she was ultimately transferred, and then they went together as a family. So that was probably best-cased transition.			