General Hospital Psychiatry 40 (2016) 55–59

Contents lists available at ScienceDirect

General Hospital Psychiatry

journal homepage: http://www.ghpjournal.com

Improving continuity of care for frequent users of emergency departments: service user and provider perspectives

Daniel Poremski, Ph.D. [a,b,*], Deborah Wise Harris, M.Ed. [b], Deborah Kahan, M.D. [c], Daniel Pauly, M.Sc. [d], Molyn Leszcz, M.D. [c,e], Patricia O'Campo, Ph.D. [b,f], Donald Wasylenki, M.D. [b,c], Vicky Stergiopoulos, M.D. [b,c]

[a] Institute of Mental Health, Singapore
[b] St. Michael's Hospital Centre for Research on Inner City Health, Canada
[c] University of Toronto Department of Psychiatry, Canada
[d] University of Toronto, Canada
[e] Mount Sinai Hospital, USA
[f] University of Toronto Dalla Lana School of Public Health, Canada

ARTICLE INFO

Article history:
Received 21 October 2015
Revised 13 January 2016
Accepted 14 January 2016

Keywords:
Continuity of care
Frequent emergency service users
Mental illness
Brief intensive case management

ABSTRACT

Objective: This study explored service user and provider perspectives on barriers and facilitators of continuity of care for frequent users of emergency departments (ED) participating in a brief intensive case management intervention.
Method: We conducted semistructured interviews with 20 frequent ED users with mental health and addiction challenges participating in a brief intensive case management intervention, eliciting experiences of care and care continuity. We interviewed 13 service providers working with this population. We used thematic analysis to determine shared and unique barriers and facilitators to continuity of care, and we gave priority to themes reported by both service users and providers.
Results: Within fragmented systems of care, strong working relationships between service users and providers, timely access to coordinated services and seamless transitions to needed supports increased perceived care continuity. Barriers to continuity of care included difficulties engaging this population, short intervention duration and the lack of a single accountable service provider to address health and social needs.
Conclusion: Although brief intensive case management interventions have the potential to improve continuity of care for frequent ED users, continuity of care, especially for people with complex health and social needs, may be compromised by program and personal characteristics as well as lack of broader system integration.

1. Introduction

Within fragmented systems of care, individuals with mental health and addictions face multiple barriers to accessing appropriate services [1], often resorting to emergency departments (ED) to address their complex health and social needs [2]. Across jurisdictions, a small proportion of ED users account for a disproportionate amount of acute care utilization [3]. People with mental health and addictions are overrepresented in this population [4]. In Canada's largest urban centre, 2% of frequent ED users with mental health or addiction challenges accounted for 20% of total visits to the ED in 2011 [5].

The possibility of reducing avoidable acute care utilization among frequent ED users has led to the development of several service models intended to facilitate continuity of care [6,7]. These models seek to eliminate barriers to accessing continued care, improve quality of care and reduce avoidable ED utilization and hospitalizations. Studies of interventions targeting frequent ED users have produced mixed results, with some studies suggesting reduced hospitalizations, and improved health outcomes in samples of people with mental illness and addictions [8,9]. These interventions commonly address immediate health needs as well as social determinants of health by facilitating access to income support and public health insurance [9].

1.1. Dimensions of continuity of care

The concept of continuity of care has evolved considerably over time and to some degree implicates a large number of overlapping constructs [10]. In this study, we have restricted our use of concepts to those outlined by Bachrach and expanded upon by Haggerty in their definitions of continuity of care. In order for care to be continuous, Bachrach suggested that "The patient is assured of a connectedness, a pattern in his care, that persists over time. The care he receives is individually prescribed for him and encompasses as many services, service providers and facilities as his particular disability requires. p1451" [11]. In other words, services must ensure (1) an orderly transition from one service to the next appropriate service and (2) uninterrupted movement as the individual transitions along diverse elements of the service delivery

* Corresponding author. Tel.: +65 6389 3634.
E-mail address: Daniel.poremski@mail.mcgill.ca (D. Poremski).

http://dx.doi.org/10.1016/j.genhosppsych.2016.01.004
0163-8343/

system. This original conceptualization mirrors what Haggerty later described as *management continuity* [12]. Haggerty expanded upon the original conceptualization to add the elements of *informational continuity*, which concerns the transmission of knowledge about patients' condition, their preference and context, and elements of *relational continuity*, which concerns consistency in the staff that people encounter while receiving care [11,12]. Together, these conceptualizations provide a comprehensive framework in which to discuss and understand continuity of care [13]. However, they are rarely applied qualitatively to explore the way in which they are experienced by service users [14–16].

1.2. Purpose

The goal of the present study is to explore the experiences of continuity of care for frequent ED users with mental health and addiction challenges participating in a brief intensive case management intervention and to identify facilitators and barriers of care continuity from the perspective of both service providers and service users.

2. Methods

We drew the study sample from the treatment arm of a larger randomized controlled trial of the effectiveness of a brief intensive case management intervention for frequent ED users implemented in Toronto, Ontario (ClinicalTrials.gov Identifier: NCT01622244; Registered 4 June 2012). The city is Canada's largest urban centre, a service-rich but fragmented care environment with long wait lists for supports. The larger trial ran from November 2012 to September 2014, recruiting a total of 166 service user participants randomized to the treatment and control arms. We obtained research ethics board approval from all six participating hospitals. The study inclusion criteria, recruitment and randomization methods, setting and intervention are detailed in Ref. [17].

2.1. The intervention

The Coordinated Access to Care from Hospital Emergency Departments (CATCH-ED) program was a brief intensive case management intervention aiming to facilitate the connection of frequent ED users with mental health or addiction challenges to appropriate community-based services [17]. By providing immediate access to brief intensive case management over 4–6 months and streamlining access to team-based primary care, the intervention sought to improve continuity of care and reduce acute care utilization. The intervention was implemented in ED across five general hospitals and one specialty mental health hospital. The five case managers (CMs) had a caseload of approximately 1:15 each and worked with program service users to develop individualized plans of care. To support program cohesion and consistency in service delivery, a program manager provided supervision to CMs and led weekly team meetings to discuss care challenges and identify ongoing training needs of CMs.

2.2. Procedure

This study includes two types of participants, service users and service providers. Members from each group were recruited to gain their understanding of the intervention and its impact. Interviewers collected service user participant demographic information and self-reported past psychiatric diagnoses at baseline. We conducted semistructured interviews with CATCH-ED service users 6 months after their baseline interview, between August 2013 and December 2013. At this time, we also conducted interviews with nine primary care providers and managers and a focus group with four of the five CATCH-ED CMs. We explored participants' experiences with the intervention, including dimensions of continuity of care described above. A peer interviewer with lived experience of mental illness conducted the interviews and focus group. The peer interviewer also played a key role in data analysis, theme interpretation and manuscript preparation.

2.3. Participants

We enrolled a total of 83 frequent ED users in the treatment arm (CATCH-ED) of the randomized controlled trial, while 83 service user participants received usual care. It is from the sample of 83 CATCH-ED service users that our qualitative service user sample was drawn. We expected to achieve saturation with the proposed sample size of 20 CATCH-ED service user participants.

The sample size for service providers was limited by the number of professionals involved with the project. All service providers who agreed or wished to participate were included. We interviewed five CATCH-ED CMs, as well as three community mental health agency managers, two primary care physicians from community health centers and three community health centre counselors. Four of the five CATCH-ED CMs participated in the focus group.

2.3.1. Inclusion criteria

To be included in the larger randomized trial of CATCH-ED, service user participants had to (1) be 18 years or older, (2) have visited an ED at least five times in the past 12 months and (3) have visited the ED at least once for concerns related to mental health or addictions.

2.3.2. Recruitment

Six months after recruitment into the larger trial, a research assistant approached service users and invited them to participate in an hour-long qualitative interview. We recruited sequentially from the caseloads of each CM until we reached the target number of 20 participants. Three service users declined participation. All participants provided written informed consent and service user participants received a $50 honorarium for their time and two tokens for public transportation to reduce barriers to participation.

2.4. Analyses

We used thematic analysis [18] to analyze the interview transcripts. To contain the analysis with a concise theoretical framework, we restricted the analysis to themes of continuity of care developed by Bachrach [11] and Haggerty [12]. To ensure methodological rigor, two members (DPa and DW-H) of the research team coded three transcripts independently and compared their findings. They used an inductive process to highlight emerging themes. Once consensus on the coding was achieved, one member (DW-H) of the research team coded the remaining transcripts. Similar codes were grouped into themes, supported by direct quotations from the transcripts. Our coding list used to analyze the data from the service providers' interviews overlapped considerably with the coding list used to analyze the service users' interviews. We gave priority to themes if they were mentioned in both service users' and providers' interviews (frequency of themes). We also considered their primacy and intensity in the interviews. We digitally recorded and professionally transcribed interviews. A member of the team checked the transcripts against the original audio file and then coded and analyzed the transcripts using NVivo 10 [19].

3. Results

Of the 20 service users who participated in the qualitative interviews, five had not been contacted by their CM and one refused CATCH-ED services at the time of the interview. The demographic characteristics of the qualitative sample, as well as those of all CATCH-ED service users, are reported in Table 1. The perceived barriers and facilitators of care continuity described below were mentioned by service user and provider participants. In all instances, themes were convergent between groups, and what was important to one group surfaced as important in the other.