Better Understanding Care Transitions of Adults with Complex Health and Social Care Needs: a Mixed Methods Study Protocol

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1. BACKGROUND

- Adults with chronic conditions who also suffer from mental health comorbidities and/or social vulnerability require services from many providers across different sector
- They may have complex health and social care needs, which necessitate a collaborative approach amongst providers to facilitate the care transitions process
- Better understanding of care transitions of adults with complex needs is essential to improve the implementation of integrated models of care [1]

2. OBJECTIVE

- To better understand care transitions of adults with complex health and social care needs across community, primary care, and hospital settings, combining the experiences of patients and their families, providers, and health managers

3. STUDY DESIGN

- Design: Two-phases mixed methods multiple case study
- Starting with a quantitative phase, followed by a qualitative phase, then by an integration of the results
- Six cases in three Canadian provinces: New Brunswick, Newfoundland and Labrador, and Quebec, each case being a set of actual care transitions across community, primary care, and hospital settings
- Three levels of analysis allowing an in-depth understanding of each case: 1) the patient level, 2) the provider level and 3) the healthcare system level
- Use of a conceptual model of factors affecting care transitions [2] to identify relevant independent variables to measure with questionnaires in phase 1, and to develop interview guides in phase 2.

Sampling patients with complex needs

In ED, screening patients with three ED visits or more in the last 12 months

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Administering COmplex NEeds Case-finding Tool (Conect-6): six items to assess the potential for complex health and social care needs

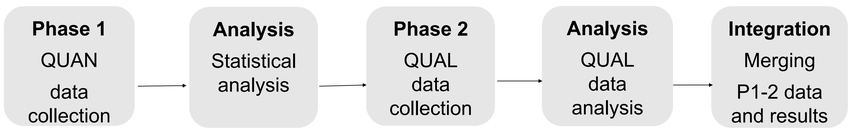
↓ When positive

Administering INTERMED self -administered: 27-item questionnaire to confirm complex care needs

↳ When positive, patient is eligible

4. DATA COLLECTION

Figure [3]



Phase 1: ***I****nitial time* - Validated questionnaires on demographic data, food security, social support, health literacy, alcohol and drug use, multimorbidity, and self management

At 6 months - Validated questionnaire to measure patient's experience of care transitions in the last 6 months

Phase 2: Interviews with patients (level 1), providers (level 2) and health managers (level 3)

Integration: A case summary synthesizing merged data will be produced for each case. Case summaries will then be compared using a descriptive and interpretative matrix [4]

5. EXPECTED RESULTS

- Better understanding of patients' experience of their whole journey regarding care transitions
- Information on how individual and environmental characteristics of patients with complex health and social care needs are associated with good or poor experiences of care transitions
- Transferable results to other contexts (lessons learned from multiple cases)

6. CONCLUSION

- Results will bring new knowledge about care transitions of adults with complex care needs using a comprehensive vision, focusing on patients' lived experiences of care transitions, and bringing together the experiences of patients and family members, providers, and community partners such as health managers.

7. REFERENCES

1. Coleman EA. Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. J Am Geriatr Soc. 2003; 51(4):549-55.
2. Arbaje AI, Kansagara DL, Salanitro AH, Englander HL, Kripalani S, Jencks SP, et al. Regardless of age: incorporating principles from geriatrics medicine to improve care transitions for patients with complex needs. J Gen Intern Med. 2014;29(6):932-9.
3. Fortin MF, Gagnon J. Fondements et étapes du processus de recherche. Montréal. Chenelière Éducation (3e ed); 2016.
4. Pluye P. Bengoechea E, Granikov V, Kaur N, Tang D. A world of possibilities in mixed methods: review of the combinations of strategies used to integrate qualitatives and quantitatives phases, results and data. Int J Multi Res Approach. 2018; 10:41-56.