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Conference Abstract

# Person-centered coordination in hospitals: A review at the crossroads of research and policy

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## Abstract

**Introduction:** Norway has sought to address challenges of discontinuity of care through legislation of a personal coordinator at both primary and speciality levels of care. In this paper, we highlight the "personal care coordinator" (PCC) which was introduced in specialized health care in 2012. The target group is patients with long-term needs of care from different departments and professions, independent of medical condition(s). The stated aim of the PCC legislation is to ensure continuity and coherence in the patient pathway, and the expectations towards the PCC role are wide and ambitious. However, no guidelines are offered for the design or evaluation of this role and there is uncertainty among service providers about how to move forward. We take the aim of the coordinator arrangement as a starting point in this paper.

**Problem statement:** In what ways can research about continuity of care inform the development of the "personal care coordinator" role within specialized health care?

**Theory and methods:** We applied a modified scoping review approach that focused on continuity of care literature on the one hand, and policy documents regarding PPC on the other. We limited our focus to literature addressing the patient perspective. Research literature from 2000-2014 were examined.

**Results and discussion:** The literature presents multiple and often overlapping understandings of continuity of care. The policy literature gives few recommendations for the design and evaluation of this role and offer no agreed definition of continuity of care.

Different understandings, dimensions and perspectives on continuity of care influence how the different coordination-of-care practices and accompanying roles for the coordinator evolve. Various models of continuity of care and possible roles of the coordinator are presented and discussed.

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Conclusions, key findings, lessons learned: Varying perspectives on continuity of care suggest differing approaches for improving coordinated care in specialized health care. Clarifying concepts and models focusing on coordinated care could offer guidance to leaders and policy makers. This would aid communication between differing contexts and stakeholders, and inform the design, implementation and evaluation of new solutions for improving coordinated care. However, more knowledge/understanding is needed about how the coordinating work currently is carried out in the clinical settings for patients with long-term complex needs.

**Limitations:** Continuity of care as the chosen perspective in the literature search is limited and covers only some of the perspectives that may be useful in informing coordination-of-care practices and coordinator roles.

**Empirical research in progress:** Studies of coordination practice in clinical settings with an institutional ethnographic approach: How is person-centred coordinating work performed today, how do the professionals understand and act towards patients' needs for continuity, and which challenges do they experience related to the introduction of new coordinator-arrangements?

## Keywords

**personal care coordinator; continuity of care; long-term chronic conditions; coordination reform**

## PowerPoint presentation

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