

## Continuum of Care

### **Problem Identification: Motivation & solution generation**

#### **Subtopic: Health services and patient transfer linkages**

**Prepared by** Chishimba, Mike, and Sam

#### Challenge: Confluent medical records

##### *Motivation*

At the moment, there are few linkages among the parties involved in providing healthcare [in Zambia]. The parties involved may include home-based care, government clinics, and hospices. One of the most important links among the parties is communication of patient medical records. These records are an essential component in monitoring patient information (i.e. clinical progression, medication regimens, diagnostic tests) when the patient is shifted from one level of care provider to another. There is, often times, reference to a patient's medical history during these transfers, in order for the patient to get proper attentions from their receiving healthcare provider, but the information is incomplete.

Medical records, if available to home-based care, government clinics, and hospices in correct and sufficient ways can help link the three individual pieces and help minimize the burden of finding out about patients history in that all the records would be readily available.

##### *Potential solutions*

The most important thing to consider when trying to solve the non-flow of patient information among all the pieces involved in healthcare [home-based care, hospices, and government clinics in Lusaka] is finding a way of keeping records that can be accessible to all the individual pieces. This can be accomplished by having a central location/database for depositing and accessing medical records by each entity or each facility maintaining their own database in which other entities have access. A mutually accessible database that can be updated by all entities should thus be a part of the link. In either case, a reference [i.e. unique patient identifier] will need to be made for each patient that is consistent among healthcare providers that is to be used for storing patient data and during referrals.

#### Challenge: Furthering education of healthcare providers

Current education of community health providers (i.e. clinical officers, community nurses, and home-based care workers) is done by different groups. Clinical officers and community nurses graduate from the University of Zambia clinical officer program and Nursing College of Zambia, respectively, while home-based care workers are typically trained by NGOs.

The whole aspect of education in home-based care has problems which have made the programs less than efficient. If this gap in education could be addressed, the delivery of community healthcare could be improved. Some of the problems/challenges in home-based care education programs include the following:

*Home-based care workers are not trained by or supervised by government clinics and/or hospices.*

The whole concept of home-based care originates from the community and not the government clinics. Whole clinics and hospices could be controlled with the formulation of education modules. Currently they are not an integral part of HBC worker training. The result of this is that most government clinics do not recognize HBC workers as trained enough to carry out basic healthcare. This not only slows or impairs referrals, but also blocks information passage between healthcare institutions. Instead of being complimentary, this lack of transparency does not allow the institutions to work together.

Another complication that arises due to fewer interaction between hospices and clinics in training of home-based care workers is that this interaction is important for the healthcare provider-patient relationship. Home-based care workers become more integral in educating patients, compared to other healthcare providers, because of time constraints for the latter. Because home-based care workers are not educated by the government clinics or hospices, they can not educate patients properly once they are discharged (i.e. medication strategy). Specifically, this includes the education of HIV/AIDS patients on ARV adherence.

This lack of educational collaboration between government clinics and home-based care workers also limits the depth of education/prevention strategies for community-borne diseases such as Cholera and TB because a large proportion of home-based care programs tend to specialize in HIV/AIDS.

*Home-based care workers typically lack the clinical know how required to effectively interface with hospices and clinics.*

Home-based care workers could better alter clinics and hospices if they had a better understanding of clinical parameters/signs to look for and communicate on. Improving home-based care worker education would allow the worker to provide more supportive information to care centers on the specific illness and patient history during referrals. Education will also help address the problem of adherence as home-based care workers better understand the clinical implications of non-adherence and strategies for promoting adherence.

#### *Possible solutions*

From the beginning of training, government clinics and hospices need to be involved with the recruitment and training of home-based care workers. That way they could dictate the clinical criteria and basic requirements for training. This can be in the form of guidance/recommendations on training or direct training, but a plan should also be made for periodic refresher or advancement courses.

## Challenge: Referral system between health centers and home-based care

### *Motivation*

The home-based care institutions should not be recruiting patients on their own, but rather should have patients referred to them. Currently, however, there are ineffective referral systems existing between government institutions (clinics) and HBC institutions. One challenge has been for HBC institutes to have adequate capacity by HBC institutes to cope with community referrals (self or family) even without government clinic referrals. Also, there seems to be no formal channels by which government clinics can refer patients who require HBC and this task is largely left to the family, community and faith-based organizations (e.g. churches). The government health institutions are ideally supposed to have social workers (social welfare department) to provide support for and cater to patients' social requirements; in some health centers where these exist, they try to form a link between government institutions and health centers. However, their services are generally inadequate, as they are poorly funded and staffed; they also have an unclear relationship (referral-wise) with the HBC centers. This sometimes leaves patients requiring HBC services stranded in government institutions.

[It should be noted that, although these deficiencies are common, some institutions have worked to create for themselves some of the structures that are lacking as a national policy. On various levels, and with various efficiencies and success, health centers do communicate HBC centers with referrals. For example, Kalingalinga Clinic, a government clinic in Lusaka, referrals *are* given to the Kalingalinga Home-Based Care program. These referrals are given for one of three reasons: 1) A new ARV patient; 2) Patients who are not getting the right nutrition and need nutrition assistance; 3) Patients who are on the "Let list", (e.g. those who do not pick up their drugs at appointed time). The referral consists of a patient name and patient file #; the HBC workers then must come to Kalingalinga clinic and look up the patient records, using the file number. The records are paper, and they are not photo copied or given to the HBC worker; information taken from the records must be manually copied. In practice, the HBC workers do take advantage of the availability of health records, and they usually make the trip to the clinic to look up the files of the patients and write down the important information.]

This problem needs to be addressed because the plight of the patients is at stake and there should be more effective utilization of resources, both at health center level, HBC level, and community level. Further, because of a lack of well-defined referral procedures, health care workers are unable to direct needy patients who would clearly benefit from HBC services. Again, this gap is not because such services do not exist, but because they do not know of procedures or such to establish the linkage. If there was a good referral system, HBC institutions would need expanded capacity to deal with government healthcare patients referred to them; they are often already overwhelmed by patients brought in by family or community members. (The capacity needs would be in terms of bed space and the human resources needed to run these HBC centers.) Solving the referral communication deficiency would effectively lead to better utilization of resources, as patients requiring HBC services would easily be referred to HBC and free up bed space and nursing demands in the already over-crowded and understaffed government centers.

*Possible solutions*

The first approach to finding a meaningful solution to the above problem is to identify and acknowledge that there are serious problems in the current system and that things could be better if we choose to make the system better. Therefore, the policy makers need to clearly outline a policy that defines the referral relationship between all HBC institutions and government centers. This must be made known to all staff, and all should clearly understand how to recommend such patients. Further, since HBCs don't have sufficient capacity to handle all patients in the case of an effective referral system, incentives and support should be given to all HBC services and provisions should be made to enable them to improve and expand their services.

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