

CONFERENCE ABSTRACT

Analyzing task division, coordination and continuity of care: A comparative case study of four specialized Multiple Sclerosis hospitals [CORTEXS]

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Introduction: Many care organizations have pushed their functional silos to the background, establishing multidisciplinary organizational units to deliver care. Yet, the way these organizational units are designed might produce differences regarding continuity of care, a key performance criterion in chronic care. Consequently, one of the questions we tried to answer in Project CORTEXS is the following: what is the relation between how organizational units are shaped and continuity of care?

Theory: Modern Sociotechnical Systems Theory is used to analyze task division and coordination throughout a care process. Task division involves how a composite task (i.e. care delivery) is divided into different tasks and how those tasks are grouped into organizational units: per function, phase or process. Coordination comprises the way task alignment between organizational units takes place, namely centralized (via supervisors or standardization) or decentralized (via direct communication). Continuity of care is conceptualized as the degree of personal follow-up that is provided throughout the care process: none, indirect or direct.

Methods: Care process are studied in four specialized Multiple Sclerosis (MS) hospitals in Flanders (Belgium). MS is a highly variable disease, presenting different symptoms and disease courses per patient, which shows the need for continuity of care. The four studied specialized MS hospitals are expected to show variety in task division and coordination. Interviews with representatives of different care disciplines are conducted in each hospital (n=28). Data are investigated using qualitative data analysis techniques.

Results: All four hospitals implemented multidisciplinary organizational units. The first hospital installed multidisciplinary departments per function (i.e. acute vs. chronic), but also split them up into work units per function (i.e. professional disciplines), aligning tasks through mixed coordination. No personal follow-up is offered throughout the care process. The second hospital created work units that deliver care throughout a particular phase (i.e. patient episodes) and aligns tasks through mixed coordination, but lacks personal follow-up between phases as well. The third hospital installed work units per phase (i.e. predefined care programs) with mainly centralized coordination. Personal follow-up between phases is missing. The fourth hospital implemented work units that provide care throughout the process (i.e. for a

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particular patient population), disregarding particular episodes or phases, with a mainly decentralized coordination. Direct personal follow-up is delivered.

Conclusions: The urge for multidisciplinary care has been translated into different practices by the four hospitals, which can be related to different degrees of continuity of care. Given the highly individual nature of MS, dividing tasks between aspects and phases that are actually interrelated does not seem to benefit continuity of care. Contrary to the expectations, mixed coordination seems to constrain continuity of care.

Lessons learned: Multidisciplinary organizational units can be shaped in various ways, resulting in different degrees of continuity of care.

Limitations and future research directions: This study looks at intra-organizational care processes only, and does not take into account legal and financial preconditions. As a part of Project CORTEXS, the study is currently being extended to investigate inter-organizational care processes and the role of legal and financial preconditions.

Keywords: organisational structure; task division; coordination; continuity of care
