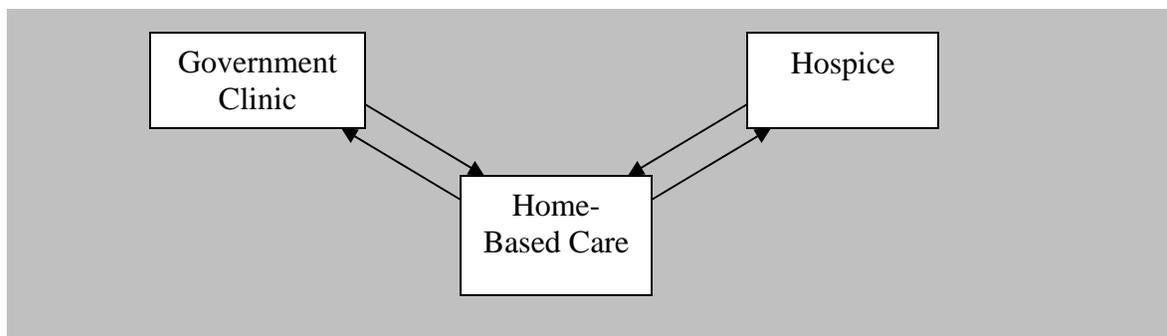


## Continuum of Care: Subtopic problem identification

Health Care Linkages – shared services and linkages between healthcare entities  
Identified by  
Chishimba and Mike

As patients move from one healthcare entity to another in Zambia, the continuity of services and healthcare between the hospice, government clinics and community level effects patients and the quality of care they receive. Smoothing the transfer of patients and information between these entities and enhancing the quality of care provided by improving these linkages is the focus of this subtopic, as it is a challenging and sometimes problematic situation.

To focus our discussion, we looked predominantly at how government clinics link to home-based care programs and how hospices link to home-based care programs. This includes how all three are integrated into a larger continuum of care and how the individual pieces link together in one or two directions. Questions we considered: How does patient information flow (i.e. clinical progression, medication, diagnostic tests) when the patient is shifted from one level of care provider to another? Are there ways to increase the capacity of one care provider in order to minimize the burden of another provider? Are there ways increase the consistency of care and information handling between care providers?



For background on these relationships, please review the UNZA student write-ups from their “Day in Matero”. As a supplement, the following information will help frame the identified problems. First, the relationship between Government Clinics and Home-Based Care: currently, with the exception of programs being developed by the CIDRZ project, Government Clinics do not train, pay or educate in any way Home-Based Care workers. Again with the exception of CIDRZ programs, there is no data flow from HBC to Government Clinics. Patients are typically cared for by the home-based care program between visits to clinics and hospitals, with little or no communication to or from the clinics and hospitals. Patients’ medical histories and records are kept at each health institution, often in a paper-based fashion, and beyond that, in the patient’s memory or personal records. Records can be retrieved if a patient returns to the same clinic or hospital, but there is no formal information transfer between different clinics, or clinic to hospital. The relationship between hospices and home-based care can potentially be stronger if the hospice is running a home-based care program; however, this is rare, and even in these cases there are not shared records or formal communication structures set up to pass on patient data or symptomatic histories.

From a training perspective, HBC workers are not robustly trained in clinical elements. Doctors, nurses and clinical officers (physician assistants) do not make home-based care rounds or typically have contact with the home-based care workers from an advisory standpoint. Clinics and hospices currently do not advise the Home-Based Care programs or use them a front-line of care or communication to the patient (again, CIDRZ is both an exception and a minority here).

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## PROBLEMS IDENTIFIED BY UNZA STUDENTS

### **Education of HBC workers**

1. Lack of knowledge / experience at HBC level; lack of exposure of HBC workers to clinicians
2. HBC workers are not trained by, paid by, or at all “controlled” by clinics or hospices. Because of this, there is not transparency between entities; HBC workers are not clinically trained or well-versed in clinical terms; and, support on treatments such as ARTs is not as effective for promoting adherence as they could be if HBC played a more formal role.
3. HBC workers do not work proactively on preventative measures or early diagnostic tactics due to lack of education and resources.
  - a. Example: the rainy season typically will bring new sicknesses such as cholera, which will eventually bring patients into clinics. If HBC workers could prepare their communities to prevent cholera and/or recognize symptoms early, they could preempt these cases before they get to the clinics and lighten the clinic’s load by providing less patients, or patients that are less progressed.

### **Medical Records**

4. A comprehensive medical history of patients is not shared between entities and often does not exist

### **Referrals**

5. Gaps exist in the recruitment of new patients to HBC programs. The recruitment pool for many HBC programs as limited, as they center on recruitment from a particular church or neighborhood. Clinics and hospices often do not recommend patients to the HBC program, thus unless patients enroll themselves in the HBC program, they will not receive Home Based Care.

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