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Continuity of care during long-term care transitions: a scoping review of the Canadian literature

Augustine Chukwuebuka Okoh^{1,4*} , Alfina Shahu², Regis Gu³, Henry Siu⁴ , Michelle Howard⁴ , Ellen Badone⁵ and Lawrence Grierson^{4,6}

Abstract

Background Patients who maintain longitudinal provider-patient relationships experience better overall health outcomes. However, most older adults in Canada lose contact with their family physician when they enter long-term care (LTC) as new providers assume responsibility for their care. There is relatively little known about the contextual factors, processes, knowledge, and health professions education antecedents that promote the benefits of relational, management, and informational care continuity during LTC transitions.

Methods Using a rigorous scoping review method, we searched multiple databases systematically to identify and scrutinize peer-reviewed articles pertaining to continuity of care during LTC transitions in Canada. Guided by Transitions Theory, two independent reviewers screened citations and extracted data. A descriptive analytical method was employed to categorize content into themes.

Results Eight articles met the inclusion criteria. Our findings confirm that instances of relational continuity are very few during LTC transitions, suggesting barriers associated with practice models and the influence of physician characteristics. Notably, the review also highlights that the involvement of interprofessional team members, patients, and their partners-in-care in transition planning could improve informational and management care continuity for patients as they move into LTC.

Conclusion Patient and family involvement, provider training, and practice and funding arrangements are all critical to improving relational, management, and informational care continuity during LTC transition. We recommend more studies to understand processes and policies to optimize informational continuity as a panacea for the often-disrupted relational continuity.

Keywords Long-term care, Transitions, Continuity of care, Relational continuity, Informational continuity, Management continuity

*Correspondence:
Augustine Chukwuebuka Okoh
okoha@mcmaster.ca

¹Department of Health Research Methods, Evidence and Impact,
McMaster University, 1280 Main St. W, Hamilton, ON L8S 4L8, Canada

²Faculty of Health Sciences, McMaster University, Hamilton, ON
L8S 4L8, Canada

³Temerty Faculty of Medicine, University of Toronto, Toronto, ON
M5S 1A8, Canada

⁴Department of Family Medicine, McMaster University, Hamilton,
ON L8S 4L8, Canada

⁵Department of Anthropology, McMaster University, Hamilton,
ON L8S 4L8, Canada

⁶McMaster Education Research, Innovation, and Theory (MERIT) Program,
Faculty of Health Sciences, McMaster University, Hamilton, ON
L8S 4L8, Canada



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Introduction

The population of older adults in Canada is growing rapidly [1], with the number of individuals 65 years and older predicted to increase to 22.7% of the population by 2031 [2]. Moreso, the population aged 85 years and older is one of the fastest-growing age groups, recording a 12% increase since 2016 and comprising about 2.3% of the general population in 2021 [2]. This growth translates to an increased need for long-term care (LTC) [3], which provides services to people who require specialized daily personal care as well as 24-h nursing care and supervision [4]. A significant number of older adults admitted to LTC have cognitive impairment or a dementia diagnosis [5]. LTC transitions may originate from the hospital or the patient's home. Transitions through the hospital occur when the patient no longer requires the level of care provided in acute care, but their care needs cannot be met in the community. This is often due to deteriorating cognitive function, functional decline, complex medical needs (e.g., wound care, intravenous therapy), or inadequate social support for a safe return home [6, 7]. Transitions from home occur due to frequent falls, declining cognitive and functional status, increased caregiver burden, and limited or no access to home care support [8].

Like most high-income countries, Canada is confronted with the challenge of meeting these complex care needs [5]. Coordination of care across the continuum is crucial to achieve efficiency and effectiveness within fragmented healthcare systems. Continuity of care is an integral part of effective coordination [9]. Continuous family physician–patient relationships are associated with the provision of coherent and consistent care, resulting in better overall health outcomes for patients [10]. Facchinetti and colleagues [3] described three types of continuity of care. *Relational continuity* refers to a longitudinal therapeutic relationship between a patient and one or more providers, entailing ongoing personal interactions between patient and provider across the life course. *Informational continuity* refers to the longitudinal use and development of information about a patient's personal preferences, values, context, conditions, and circumstances by providers to make current care appropriate for that individual. *Management continuity* refers to a coordinated approach to managing a health condition by adapting to a patient's changing needs. It is crucial for complex, chronic conditions requiring input from multiple providers. The focus is on maintaining a consistent treatment plan rather than provider continuity, ensuring all involved healthcare providers align with the established care plan regardless of when they join the patient's care.

Several studies report that strong care continuity is associated with better prescribing; reduced rates of hospital admissions, emergency department visits, and mortality [11, 12]; better compliance with therapy; improved

physician and patient satisfaction; improved preventative care; and lower healthcare costs [13, 14]. However, when older adults in Canada transition from independent living in the community to LTC, their ongoing relationship with their family doctor is disrupted and not typically maintained. This is because most residents in Canadian LTC homes receive care from staff physicians and other care providers contracted and employed, respectively, by the LTC homes [15]. In this regard, we recognize that a substantial proportion of Canadian older adults entering LTC experience a disruption of relational continuity with their healthcare team.

The current standard of information exchange during LTC transitions in Canada involves the submission of LTC Health Assessment Form by the patient's family physician (in the case of transitions from community) or nursing/social work team (in the case of transitions from the hospital) [16, 17]. The form ensures the LTC home receives information pertaining to allergies and drug sensitivities, current medications, and a brief medical history, but does not provide an opportunity for the healthcare professional to report on non-medical care, medications that were tried and abandoned as well as the rationale, and patient values and preferences. Using a form that contains both non-medical and medical information about a LTC resident may enable smoother and more consistent care.

While some research studies have explored the continuity of care during LTC transitions in Canada, no rigorous review has been completed on this topic. Accordingly, we posed the following research questions: *What is the evidence about continuity of care during LTC transitions in Canada? What processes, practices, and factors related to family physicians, patients and family caregivers influence (relational, informational, management) continuity of care during LTC transitions in Canada?* The following scoping review, thus, aimed to map the evidence on the practices and factors influencing continuity of care during LTC transitions in Canada. We limited this review to Canada as having a better understanding of the collected evidence in this space, through the current scoping review, will inform the generation of contextually [Canada] relevant policies and practices and highlight pervasive knowledge gaps that require targeted research. We are relying on Meleis's *Transitions Theory* [18] for this review. The theory is important because it considers health events that prompt transitions from one care setting to another (e.g., primary care to LTC), the nature of transition, and facilitators and barriers of successful transitions. *Transitions Theory* also serves as a sensitizing framework for the review; it draws our attention to the roles of various actors in a patient's transition and the organizational features of family medicine practices and LTC facilities that affect this transition.

Methods

Research design

With our research questions articulated, this comprehensive scoping review was conducted according to the framework outlined by Arksey and O'Malley [19], which includes steps of identifying relevant studies; study selection; charting the data; and collating, summarizing and reporting the results. Scoping review designs are particularly appropriate to answer broad questions [20]. We all followed the Joanna Briggs Institute guidelines, which are consistent with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (the PRISMA-ScR) [21].

Identifying relevant studies

A comprehensive literature search was conducted in May 2024. We retrieved literature from six databases – Ovid Medline, EMBASE, EMCARE, AGELINE, CINAHL and PsycINFO. The search was limited to peer-reviewed papers and grey literature published in English, and specific to continuity of care during transitions to LTC in Canada. Grey literature via government and Canadian health organizations' webpage did not yield any relevant information on continuity of care during LTC transitions. We did not set a date limit because we did not anticipate encountering a large quantity of literature on the topic. Our search strategy was developed with the help of a Health Sciences librarian at McMaster University based on three core concepts: Long-term care, Continuity of care, and Canada. The search strategy included a combination of medical subheadings (MeSH) and keywords – “nursing home” OR “nursing home care” OR “skilled nursing facilities” OR “long-term care” OR “long-term services and supports” AND “continuity of patient care” OR “patient care continuity” OR “patient handoff” OR “patient transfer” OR “retention in care” OR “transition to adult care” OR “transitional care” OR “Care continuity” OR “continuity of care” OR “informational continuity” OR “relational continuity” OR “patient handover” AND “Canada” OR “Alberta” OR “British Columbia” OR “Manitoba” OR “New Brunswick” OR “Newfoundland and Labrador” OR “Nova Scotia” OR “Northwest Territories” OR “Nunavut” OR “Ontario” OR “Prince Edward Island” OR “Quebec” OR “Saskatchewan” OR “Yukon” – for each database.

Study selection

We included studies if: i) they focused on continuity of care [3] during transition to LTC; ii) participants included family physicians, older adults, and/or family partners-in-care; iii) the study was conducted in the Canadian context; and iv) the paper used either quantitative, qualitative, or mixed-methods study design but not a review, commentary or case series. Delimitation to

Canada ensured we elicited evidence that is relevant to the Canadian healthcare system. We excluded any papers that studied continuity of care outside of transitions from home and/or hospital to LTC.

Screening began with review and appraisal of titles and abstracts. Articles deemed suitable after this assessment were then forwarded to full-text review. Initial title and abstract screening and full paper review were conducted by two independent reviewers (AS, RG). Disagreement in screening decisions was resolved through discussion with a third research team member (ACO) during regular team meetings. Covidence (Veritas Health Innovation Ltd., Melbourne), a tool designed to manage and streamline the process of conducting systematic reviews, was used to organize the screening process and create an audit trail for decisions [22].

Data charting

Two research team members (AS, RG) conducted data charting independently, and a third team member (ACO) confirmed the data. We approached data charting with consideration for *Transitions Theory*, which draws our attention to the types and patterns of healthcare transitions and the properties of transition experiences for patients and providers when making sense of the facilitators and inhibitors of effective transition outcomes [18]. In the context of this study, it prompted us to contemplate the roles of the various agents in a patient's transition, the health concerns that prompt transitions, and the relevance of organizational features of the family medicine practices and LTC facilities at either end of the transition trajectory [18]. Accordingly, our data extraction framework supported the collation of study information on patient characteristics, provider characteristics, caregiver characteristics, LTC home characteristics, types of continuity studied (i.e., relational, informational, management), transition pattern (i.e., moving from hospital to LTC or home to LTC), and study outcomes alongside information about article characteristics: publication details (authors, title, publication year), study design, and geography (*vis-a-vis* provincial or territorial context).

Collating, summarising, and reporting results

After organizing the information in the data charting form, we employed a descriptive qualitative analytical method [21] to synthesize data derived from the included studies and to produce a thematic construction of the LTC transition evidence [19]. The first author (ACO) developed the first set of themes and subthemes. Guided by *Transitions Theory* [18], the initial coding involved extracting concepts from the included studies pertaining to transitions to LTC. The next stage involved finding patterns across concepts and aggregating concepts to developed themes and subthemes. The themes and subthemes

were refined through iterative discussions with another author (LG). The themes and subthemes and interpretation of results were reviewed by the full research team, who have expertise in primary care and care of the elderly research, for accuracy and relevance to the Canadian practice and policy context. Also, if a paper did not mention the type of continuity explicitly, the research team determined the type of continuity through close reading of the text with reflection on Facchinetti and colleagues' [3] definitions of relational, informational, and management continuity. Two research team members (ACO, LG) were involved in this process. We created summaries and reported the results following the PRISMA-ScR checklist [23].

Results

Our search yielded 1,950 articles. After deduplication, 1,562 citations underwent abstract and title screening, and 35 studies were eventually advanced to full-text screening. Ultimately, eight articles were deemed appropriate for inclusion in the review (Fig. 1). No new publications were included after reviewing the references of the included papers and the grey literature.

Description of included studies (Table 1)

Research designs

This scoping review included one quantitative study [31], five qualitative studies [24, 27–30], and two mixed-methods studies [25, 26].

Geography

One study was conducted in Alberta [29], two in British Columbia [27, 30], and four in Ontario [24, 25, 28, 31]. One study did not indicate the study setting [26].

Populations

The study population in the included papers comprised older adult patients [24, 25, 28, 31], family partners-in-care [26, 27], and family physicians [24, 28–31]. While the continuity of care discourse focuses on patient-physician relations, the papers recognized other healthcare providers were also mentioned as members of the interprofessional team.

Transitions

One study focused exclusively on home-to-LTC transitions [27] and two studies interrogated hospital-to-LTC transitions exclusively [24, 25]. The remaining five articles researched both transition types.

Continuity of care

One study explored only relational continuity [31], while two studies explored only informational continuity [24, 25]. One study explored relational and management

continuity [30], three studies explored informational and management continuity [26, 27, 29], and one study explored relational, informational, and management continuity [28] Table 2.

Continuity practices during LTC transition in Canada

One paper revealed a high rate (87.9%) of disrupted relational continuity after moving into LTC in Ontario [31]. Indeed, all the collected literature affirmed that instances of relational continuity are very few during LTC transitions. In our review, it was notable that the papers, even those that included *foci* on informational and management forms of continuity, did not present evidence of these forms of continuity being leveraged to ameliorate and/or mitigate the impact of the provider-patient relationship disruption. In this we infer that little attention has been given to the way information and/or management plans may be utilized to improve the quality-of-care received by LTC residents.

Factors influencing continuity of care during LTC transition

While we identified no studies that explored the potential of informational and management forms of continuity to offset relational disruptions, we were able to delineate factors that influence the effectiveness of relational, informational, and management continuity of care during LTC transitions. These were grouped into three thematic areas: stakeholder engagement, practice features, and physician characteristics (Table 3). Our analysis, thus, describes perspectives and elements pertaining to the maintenance and/or enhancement of continuity of care during LTC transitions.

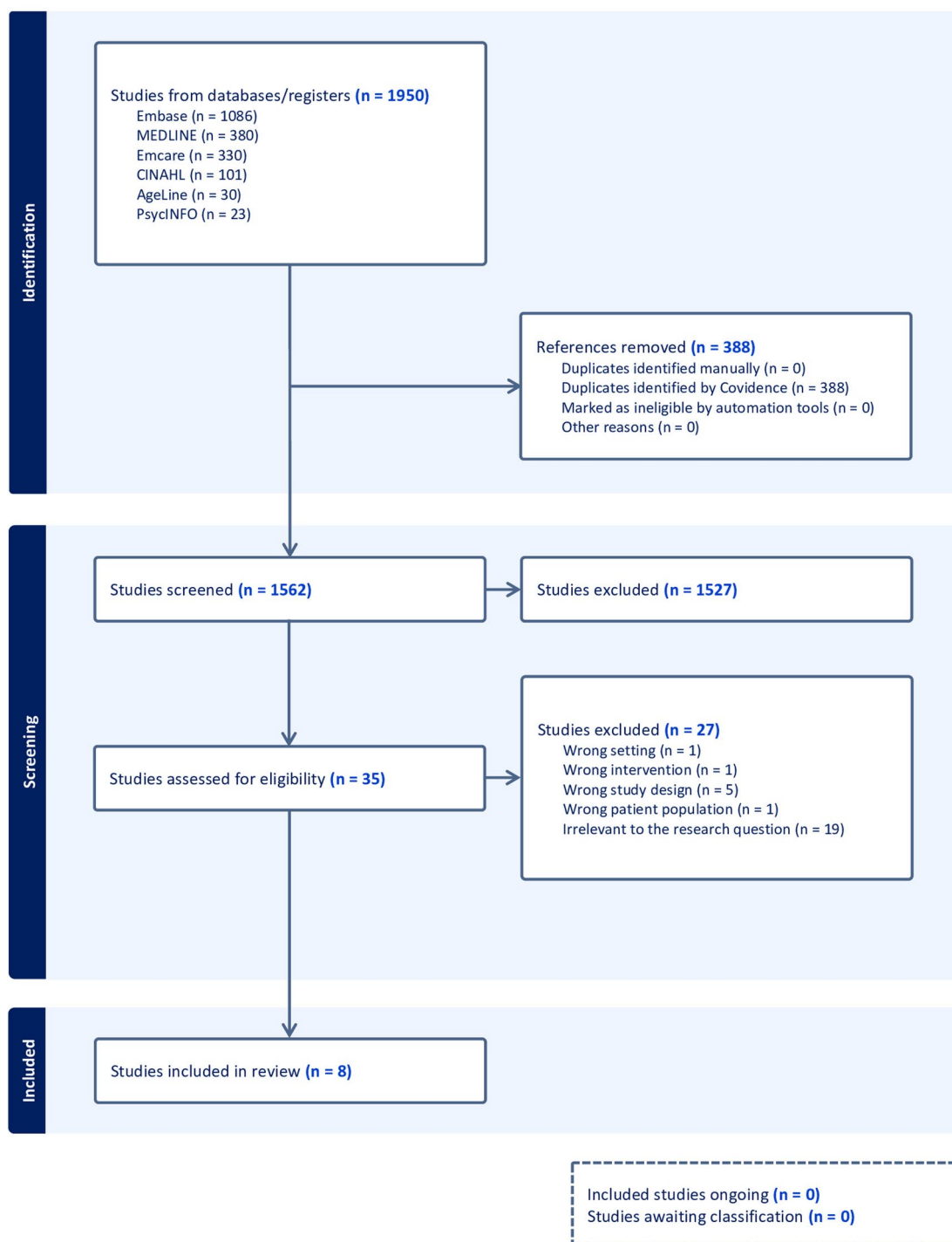
Stakeholder engagement

Most saliently in the review, several papers [24–29, 31] considered the facilitation of informational and management continuity through collaboration between different stakeholder groups during the LTC transition. The integration of patients, their partners-in-care, and family physicians and a diverse group of providers in the transition process is pertinent to improving continuity of care for LTC residents. The information exchange studied incorporated written and verbal communication forms; both of which contribute meaningfully to improving transitions of care. The studies reported on collaborative interactions between community family physicians, LTC physicians, and other members of the interprofessional team. They also encouraged the active involvement of patients and partners-in-care in the transition process.

Interprofessional team

Two papers focused on the critical role of interprofessional collaboration and communication to facilitating informational continuity and better care outcomes

Continuity of care during LTC transition



19th October 2023

**Fig. 1** PRISMA flowchart of study inclusion process

Table 1 Summary of the key features of included papers (n = 8)

Author (Year)	Study design	Jurisdiction (s); Rurality	Population studied	Transition pattern		Type of continuity studied		
				Hospital to LTC	Home to LTC	Relational	Informational	Management
Abdool et al. (2015) [24]	Case study	Ontario; Rurality(n/s)	Healthcare providers; Patients	✓			✓	
Baetz-dougan et al. (2021) [25]	Convergent mixed methods design: survey and focused group	Ontario; Urban	Patients	✓			✓	
Gorenko et al. (2021) [26]	Sequential explanatory mixed methods design: secondary data analysis and individual interviews	n/s	Family partners-in-care	✓	✓	n/s	n/s	n/s
Hainstock et al. (2017) [27]	Qualitative description	British Columbia; urban, sub-urban, and rural	Family partners-in-care	✓	✓	n/s	n/s	n/s
King et al. (2022) [28]	Case study	Ontario; urban	Healthcare providers; Patients; Family partners-in-care	✓	✓	✓	✓	✓
Olke et al. (2009) [29]	Case study	Alberta; Rural	Healthcare providers	✓	✓		✓	✓
Sloan & Buchanan (1993) [30]	Document analysis—Reviewed 60 charts	British Columbia; urban	Healthcare providers	✓	✓	✓		✓
Staykov et al. (2020) [31]	Retrospective cohort study	Ontario; Urban and rural	Healthcare providers; Patients	✓	✓	✓		

✓ = present in that study
n/s = not specified

Table 2 Summary of the relevant results of the included papers ($n = 8$)

Author (Year)	Objectives	Results
Abdool et al. (2015) [24]	To highlight the current gap in legislation for difficult transition cases involving unrepresented patients and provide a novel framework for who ought to assist with making these decisions and how these decisions ought to be made	Considerations of patients' values as well as their healthcare needs into the goals of care and placement decisions. The decision to LTC should be made in collaboration with the patient or their substitute decision maker.
Baetz-dougan et al. (2021) [25]	To assess the perceived ease of use, usefulness, and care-enhancing potential of the North York General Hospital-LTC (NYGH-LTC) Transfer Form by interprofessional LTC staff	Information sharing and communication facilitate continuity of care, especially improved bidirectional verbal communication (between the before- and after-transition provider) in addition to filling out the LTC transition form.
Gorenko et al. (2021) [26]	To examine how caregiving and transitioning a family member into long-term care (LTC) influence planning	Caregivers with LTC transition experience engaged in more planning than non-caregivers. Continuity of care was supported by caregiving experience, clear care expectations, and social support from loved ones (their significant other, family and friends).
Hainstock et al. (2017) [27]	To explore the roles and responsibilities of family caregivers for family members making the care transition from home care to residential care (LTC)	Family caregivers play a vital role in care transitions by gathering information, advocating, and navigating the healthcare system to ensure continuity of care. To better support them, there is a need for increased investment in strategies that enhance communication and education for caregivers.
King et al. (2022) [28]	To examine how a goal-oriented approach impacts (facilitates or inhibits) continuity of care in a long-term care setting	Facilitators of continuity of care include engaging stakeholder- resident, care team, and family- in LTC transitional care discussions, counselling, and consultations. Also, incorporating residents' values and preferences and family's perspective in transitional care planning formed a holistic understanding of a resident are important facilitators. Lack of awareness and clear information on the transition agenda inhibited continuity of care. Another barrier is the unavailability of family and other partners-in-care when for incompetent patients/ LTC-residents.
Oelke et al. (2009) [29]	To explore the successes of Primary Care Networks (PCNs) in facilitating integration across the continuum, i.e., primary care, specialty services, acute and long-term care	Collaborations in Alberta's PCNs has evolved beyond primary care to include interrelations with acute care and LTC. The collaboration involves document exchange, chart reviews, and transdisciplinary team meetings. Information exchange among clinic physicians, continuing care and emergency medical services, and system navigators to facilitate integration and informational continuity. This integration created opportunity for interprofessional collaboration and improved outcomes for LTC residents.
Sloan & Buchanan (1993) [30]	To explore whether physicians with many patients in a long-term care facility provide more timely follow-up of their drug orders than those with only a few	Open physician staffing model is associated with greater likelihood of follow up and relational continuity compared to the typical closed physician staffing model. In smaller communities, follow-up care often depends on a physician's interest in LTC; those who expressed a passion for it tend to take on more patients. Also, factors like geography and payment can further limit access to continuity-based care.
Staykov et al. (2020) [31]	To determine the proportion of LTC residents who retain their community family physician within the first 180 days of LTC, and the resident, physician, and LTC home factors that may influence retention	Resident health, LTC home geography, and family physician demographics and practice patterns influenced relational continuity. About 87.9% of LTC residents do not retain their family physicians post-LTC admission. Longer distance (30 + km) from the LTC home to the family physician's clinic, being a female physician, an international medical graduate, and a capitation-based remuneration structure are associated with lower retention. The same applies to practising in an urban area, having billed LTC fee codes in the past year.

during LTC transitions [25, 29]. Baetz-Dougan and colleagues [25] recommended enhanced bidirectional communication between the before- and the after- transition care providers to enhance informational and management continuity. The other study reported that integrated

care practices such as data sharing among the primary care, continuing care, and emergency care services fosters interprofessional collaboration and is associated with improved care outcomes for LTC residents [29]. In their case study in a rural community in Alberta, Oelke

Table 3 Thematic presentation of factors influencing continuity of care during LTC transition

Themes	Subthemes	Type of continuity impacted		
		Relational	Informational	Management
Stakeholder engagement	Interprofessional team		✓	✓
	Patient involvement		✓	✓
	Partners-in-care		✓	✓
Practice features	Practice location	✓		
	Staffing models	✓		
	Remuneration models	✓		
Physician characteristics	Gender	✓		
	Location of medical education	✓		
	Professional interest	✓		

and colleagues [29] found that encouraging information exchange creates opportunities to build closer working relationship between physicians and other interprofessional team members (e.g., pharmacists, social workers, nurses) and enhances communication and efficient services delivery. They also found that a community-to-LTC transition navigated with the support of interprofessional team members, in the form of a comprehensive care transition note/plan, resulted in high-quality care continuity for LTC residents.

Patient involvement

Four papers [24, 26, 28, 31] suggest that LTC transitions should include active patient involvement. In line with management continuity, studies reported that the LTC transition process and the care plans developed during LTC transitions should be made collaboratively with the patient and their family [24]. The quality and usefulness of transition information can be improved by integrating patient values and preferences into the goals of care transition, including the planning of placements and interventions [28]. Accordingly, Abdool and colleagues [24] reported that planning LTC transitions with the older adult patients fosters the patient-centered care model in LTC. In addition, a mixed methods study by Gorenko and colleagues [26] showed that older adults with a previous LTC transition experience for a relative are often better prepared for and contribute significantly to planning their own LTC transition than those without the experience. Thus, some patients, those with lived experience of LTC transitions, can also offer valuable inputs that may enhance not only informational continuity but also management continuity [26].

Partners-in-care

Five papers [24, 26–28, 31] offer that the involvement of partners-in-care, including family members and friends, in transition planning is pertinent to achieving effective informational and management continuity. A qualitative inquiry revealed that during LTC transition, family partners-in-care support the patient specifically through

information gathering, advocacy, and navigating the healthcare system [27]. Additionally, two studies [26, 28] recommended that family partners-in-care should participate in transition care conferences to discuss care options and goals (i.e., management continuity) and gain insight into and offer perspectives on what patient information should be collected (i.e., informational continuity). This is based on the assumption of an existing close longitudinal relationship family partners-in-care have with the older adults, qualifying them as competent representatives of their older relative [26]. Notably, a paper we reviewed highlighted that a large proportion of older adults admitted to LTC have cognitive impairment and a dementia diagnosis [31]. These older adults are often unable to articulate their values and preferences during the LTC transition. Thus, the patient health care history and transition goals of these older adults need to be communicated through their substitute decision-maker [24].

Practice features

Two studies [30, 31] included in the review reported on the environmental, organizational, and financial factors that bear influence on the attainment of continuity of care during LTC transitions. These factors were organized around the family physician's practice location, the LTC home's staffing models, and physician remuneration models.

Practice location

The geographic disposition of the family physician's practice influences the likelihood of continuing to provide care for their patients who enter LTC [30, 31]. The evidence shows that family physicians in rural practice or small towns are more likely to continue providing care to their patients after moving into LTC than those practicing in large urban locations [30, 31]. In rural areas, however, distances greater than 30 kms between the family physician's clinic and the LTC home hindered relational continuity [31]. The rationale proposed by the authors indicated that longer distances for rural physicians and the time commitment involved in travel for urban

physicians may pose an additional workflow complexity to family physicians who already grapple with high overhead cost and administrative tasks.

Staffing models

These studies also reported on LTC staffing models, highlighting the differences between closed and open models [30, 31]. In a closed model, also known as the *house doctor* model, LTC-contracted physicians are responsible for the care of all LTC residents [30]. In contrast, in an open model, family physicians attending to residents are not direct employees of the LTC home [30, 31]. The studies revealed that in open staffing models, physicians are more likely to continue caring for their patients even after they move into LTC, promoting relational continuity. The open physician staffing model is more prevalent in rural settings, which have fewer service options; unlike urban settings, which often have a greater number and wider range of healthcare professionals and specialty groups [31]. However, Sloan and Buchanan's [30] document review in a British Columbian LTC facility revealed that closed staffing models foster management continuity in larger urban LTC facilities following the transition from community to LTC. Additionally, their study findings suggested that *house doctors* in urban LTC settings conduct more visits, provide more care, and follow-up on treatment progress more often compared to those operating in open models.

Remuneration models

One of the two papers reported that the physician remuneration model and the availability of physician LTC billing codes could either enhance or hamper relational continuity during LTC transition [31]. In their retrospective cohort study in Ontario, Staykov and colleagues found that family physicians in the capitated rostered patient payment model were less *likely* to continue delivering care to their patients in LTC compared to those in a fee-for-service payment model. They suggested that physicians in fee-for-service models may prefer patients with complex needs, which are common in LTC, because of increased remuneration associated with billing codes for treatments for complex patients. Furthermore, they found that family physicians who have billed for LTC within the last year have a higher likelihood to practice in LTC, and potentially maintain relational contact with their patients, than those who did not.

Physician characteristics

A few physician characteristics appeared once across the reviewed papers as influencing continuity during the LTC transition process. These less represented but still present factors included the physician's gender, location of medical education, and professional interests.

Gender

One paper noted that family physicians who identify as men were reported as having a higher likelihood of practicing in the LTC space and continuing to care for their patients entering LTC compared to their counterparts who identify as women. In their retrospective cohort study, Staykov and colleagues [31] revealed that the odds for family physicians who identify as women to practice in LTC are 10% lower than their counterparts who identify as men.

Location of medical education

One study found that family physicians trained in Canada were more likely to practice in LTC homes than their foreign trained counterparts [31]. Their analysis also showed that foreign trained physicians had 11% lower odds of LTC practice and thus less likely to maintain relational continuity when their patients move into LTC than those trained in Canada.

Professional interest

One study highlighted the crucial role of a physician's interest to practice in LTC on relational continuity [27]. They found that family physicians who reported an interest in or enjoyment of LTC are more likely to follow their patients as they enter LTC than those who do not. They also noted that these family physicians accumulate more LTC residents in their practice than those who did not report a predilection to practice in LTC.

Discussion

This scoping review synthesized practice and contextual factors that influence continuity of care during the LTC transitions. We noted that instances of relational continuity are very few during LTC transitions in Canada. Indeed, it may not be feasible to establish relational continuity as the standard practice during in LTC transitions in Canada due to structural and policy barriers. For instance, the disruption of relational continuity is most prevalent in urban locations, wherein LTC homes operate a "closed" physician staffing model that sees LTC-contracted physicians assume primary responsibility of care for all residents. It is further exacerbated when older adults are placed in a home that does not share a relative geographic disposition with their family physician's office, a reality many faced when the Government of Ontario enacted *Bill 7 – More Beds, Better Care Act* (2022) – which authorized temporary LTC placements as far as 150 km away from the patient's preferred LTC home [32]. In these situations, enhancing informational and management continuity becomes even more critical to meeting the policy goals of fostering LTC resident dignity, ensuring their security and comfort, and adequately

meeting their physical, psychological, social, spiritual, and cultural needs [3, 17, 33, 34].

The production and transfer of comprehensive patient healthcare information during the LTC transition would foster informational and management continuity. We conceptualize *comprehensive* patient healthcare information as the relevant environmental, social, mental, and physical health information that is required to support continuity of care for an older adult in LTC [35]. Given the review highlights that informational and management continuity are improved through wide stakeholder engagement in LTC transition planning, this could be achieved through the effective collaboration of a team of interprofessional healthcare providers, patients, and their partners-in-care when navigating the LTC transition. This aligns with a study in the United States showing that communication and interdisciplinary care team meetings between the before- and after-LTC transition providers is effective in promoting informational and management continuity of care [36]. Similarly, *Transitions theory* underscore that effective stakeholder engagement and interactions in the transition process results in better outcomes [18]. Another review which scoped the literature from the developed countries also affirmed that collaboration and communication between older adults and their formal and informal partners-in-care is pertinent to facilitating informational and management continuity [37]. As jurisdictions across Canada move toward a greater healthcare system integration, a pilot study [38] aggregated the opinions of healthcare leaders across Canada to infer an imperative to prioritize informational and management continuity.

Transitions theory offer that one's identity and organizational features shape the transition process [18]. In this regard, a spate of other factors was also lightly reflected in our analysis, often appearing as relevant in only one or two reviewed papers. These included physician characteristics and practice features. Notably, one such factor was the influence of location of medical education. The location of medical education bears relevance to the interest of family physicians to practice in LTC, and the likelihood to continue caring for their community-based patients who enter LTC homes. Canadian-trained family physicians have exposure to structured rotations in LTC during residency [39]. This exposure may be more variable for foreign trained family physicians, and therefore, they may be less comfortable providing care for their patients when they move into an LTC home. This is also supported by evidence showing that geriatrics education elevates interest and competency to practice in settings that manage older adults such as LTC [40].

When considering the practice behaviours of foreign trained physicians, it is important to acknowledge that there are several policies that incentivize foreign-trained

physicians to work [at least in the short term] in rural and other underserved areas in Canada [41, 42]. As Staykov and colleagues [31] reported, open staffing models are more prevalent in these settings. Collectively, then, we might expect foreign trained physicians to be more likely to follow patients into LTC. However, subsequent reports highlight that many foreign-trained physicians ultimately relocate to urban locations [42, 43] which commonly operate the closed physician staffing model that is associated with greater loss of relational continuity. In this regard, leveraging foreign trained physicians to meet rural needs has not been effective so far; at least in terms of promoting relational continuity during LTC transitions – however, there is evidence that suggests that there may be some benefits in rural areas associated with employing physicians with a rural background or who complete their undergraduate or postgraduate training in rural areas [43–46].

Furthermore, a physician's gender may influence relational continuity during LTC transition. One paper in our review suggested that family physicians who identify as women are less likely to maintain relational contact with their patients who enter LTC; this corroborates results from previous studies which reported that women physicians often encounter significant work-life balance challenges which can affect their availability for LTC roles which typically require frequent off-duty telephone calls and onerous paperwork [47–50].

The transition patterns reported included both hospital to LTC and home to LTC transitions. A report in Canada showed that between 2018 and 2019, about 40% of LTC residents transitioned directly from hospital and the rest transitioned directly from home-based settings such as assisted living facilities and their private residences [51]. They affirmed that most older adults who move into LTC have complex care needs [51]. Nonetheless, another study [31] reported that a fee-for-service physician remuneration model is linked to increased motivation to practise in LTC and maintain relational continuity compared to the capitated system. Physicians in a fee-for-service model are disposed to LTC practice as LTC residents' frequent care needs may result in increased revenue. This corroborates existing evidence which reports that fee-for-service model incentivizes higher volume of visits which may be a desirable model for providing care for patients with high and frequent care needs [52–54].

Regardless of physicians' gender, remuneration models, or location of medical education, we believe their decisions are understandable and not necessarily unwarranted. Despite the underlying reasons behind their choices, foreign-trained physicians, women physicians, and those in a variety of remuneration models clearly play an important role in ensuring informational and management continuity. In each case, this can be

achieved through a strong commitment to information exchange and by actively involving interprofessional teams, patients, and patient partners in transition planning. Such efforts underscore the importance of stakeholder engagement, as it is vital for fostering seamless care transitions and optimizing patient outcomes. By reinforcing these practices, healthcare systems can better support the diverse needs of physicians and the communities they serve, including the key roles they play during LTC transition to foster relational, informational, and management continuity.

Based on this review, we are not positioned to offer definitive recommendations to policymakers and other stakeholders. However, the scoping review outlines the contours of the research landscape and has helped us speculate on the policy areas where recommendations may emerge. These include policy reforms to ensure: i) communication between community family physicians and LTC physicians during the LTC transition process; ii) engagement of the interprofessional healthcare team in the development of LTC transition paperwork; and iii) involvement of patient and/or partners-in-care in the development of LTC transition paperwork.

Limitations

Our review found only eight relevant empirical studies on continuity of care during LTC transition in Canada, highlighting the limited research available. Moreover, very fewer papers examined physician characteristics (gender, the location of their medical education, and physician's interest) and practice features (practice location, staffing model, and remuneration model). This gap suggests a need for more comprehensive investigations. While the existing studies offer valuable insights, they are insufficient for drawing strong conclusions or fully understanding the influence of physician characteristics and practice features on continuity of care during LTC transition. Future research should explore these under-researched themes to expand the empirical evidence and to better informing policy and practice related to transition to LTC in Canada.

Also, since we conducted our review on English language papers only, we may have missed critical French language pieces relevant in some jurisdictions in Canada, e.g., Quebec. Lastly, while we reported on gender, the one study [31] that provided this insight used sex-based terminology. We may have incorrectly supposed that gender was the more appropriate construct, assuming that the authors used male and female categories based on participant self-reports. In any event, even if our assumption is correct, we cannot confirm whether participants provided answers that reflected gender, biological sex, sex assigned at birth, or some other related construct.

Conclusions

Continuity of care is pertinent to ensure that the LTC system can continue to meet the complex care needs of older adults. However, the review shows that very little research has been done in Canada on this subject area. Inasmuch as relational continuity is lost during transition to LTC, limited attention has been given to informational and management continuity during the LTC transition. However, there is strong support for the idea that improving the integration of all relevant stakeholders can improve continuity of care for patients during LTC transition. Future studies should explore innovations that leverage informational continuity to optimize outcomes of care when older adults enter LTC.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions

ACO and LG contributed to the concept of the study. AS, RG, ACO contributed to the literature screening and data charting. ACO, LG, HS, MH, EB contributed to the preparation of the draft manuscript. All authors contributed to the synthesis of the literature and the review/approval of the manuscript.

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Data availability

Data is provided within the manuscript and the supplemental information files.

Declarations

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Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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References

1. UN DESA. World Population Prospects 2019: Highlights| Multimedia Library - United Nations Department of Economic and Social Affairs. United Nations. 2019. <https://www.un.org/development/desa/publications/world-population-prospects-2019-highlights.html>. Accessed 23 Sept 2022.
2. Statistics Canada. The Daily — Canada's population estimates: Age and sex, July 1, 2021. 2021. <https://www150.statcan.gc.ca/n1/daily-quotidien/210929/dq210929d-eng.htm>.
3. Facchinetti G, D'Angelo D, Piredda M, Petitti T, Matarese M, Oliveti A, et al. Continuity of care interventions for preventing hospital readmission of older people with chronic diseases: a meta-analysis. *Int J Nurs Stud*. 2020;101:103396.
4. Banerjee A. An overview of long-term care in Canada and selected provinces and territories. Women and Health Care Reform. 2007. http://www.womenandhealthcarereform.ca/publications/banerjee_overviewLTC.pdf.
5. OLTCA. The Data: Long-Term Care in Ontario. Ontario Long-Term Care Association. 2024. <https://www.oltca.com/about-long-term-care/the-data/>. Accessed 9 Aug 2024.
6. Aase K, Waring J. Crossing boundaries: establishing a framework for researching quality and safety in care transitions. *Appl Ergon*. 2020;89:103228.
7. Moreno-Martin P, Jerez-Roig J, Rierola-Fochs S, Oliveira VR, Farrés-Godayol P, de Bezerra Souza DL, et al. Incidence and predictive factors of functional decline in older people living in nursing homes: a systematic review. *J Am Med Dir Assoc*. 2022;23:1815–1825.e9.
8. Gentili S, Riccardi F, Gialloreti LE, Scarcella P, Stievano A, Proietti MG, et al. Admission to the long-term care facilities and institutionalization rate in community-dwelling frail adults: an observational longitudinal cohort study. *Healthcare*. 2022;10:317.
9. Rudoler D, Peckham A, Grudniewicz A, Marchildon G. Coordinating primary care services: a case of policy layering. *Health Policy (New York)*. 2019;123:215–21.
10. CFPC. A New Vision for Canada. 2019. <https://www.cfpc.ca/en/resources/patient-s-medical-home/a-new-vision-for-canada-family-practice-the-patient>.
11. Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. *BMJ*. 2017;356:84.
12. Te Winkel MT, Damoiseaux-Volman BA, Abu-Hanna A, Lissenberg-Witte BJ, van Marum RJ, Schers HJ, et al. Personal continuity and appropriate prescribing in primary care. *Ann Fam Med*. 2023;21:305–12.
13. Chan KS, Wan EYF, Chin WY, Cheng WHG, Ho MK, Yu EYT, et al. Effects of continuity of care on health outcomes among patients with diabetes mellitus and/or hypertension: a systematic review. *BMC Fam Pract*. 2021;22:145.
14. Ridd MJ, Santos Ferreira DL, Montgomery AA, Salisbury C, Hamilton W. Patient-doctor continuity and diagnosis of cancer: electronic medical records study in general practice. *Br J Gen Pract*. 2015;65:e305–11.
15. Collins R, Charles J, Moser A, Birmingham B, Grill A, Gottesman M. Improving medical services in Canadian long term care homes. *Can Fam Phys*. 2020. <https://www.cfp.ca/news/2020/10/07/10-07>. Accessed 9 Aug 2024.
16. Kelly KJ, Doucet S, Luke A. Exploring the roles, functions, and background of patient navigators and case managers: a scoping review. *Int J Nurs Stud*. 2019;98:27–47.
17. Government of Ontario. Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1. 2021. <https://www.ontario.ca/laws/statute/21f39>.
18. Meleis AI. Transitions theory. *Nursing Theories Nurs Pract*. 2015;4:361–80.
19. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol Theory Pract*. 2005;8:19–32.
20. Sucharew H, Macaluso M. Methods for research evidence synthesis: the scoping review approach. *J Hosp Med*. 2019;14:416–8.
21. Peters MDJ, Marnie C, Tricco AC, Pollock D, Munn Z, Alexander L, et al. Updated methodological guidance for the conduct of scoping reviews. *JBI Evid Synth*. 2020;18:2119–26.
22. Harrison H, Griffin SJ, Kuhn I, Usher-Smith JA. Software tools to support title and abstract screening for systematic reviews in healthcare: an evaluation. *BMC Med Res Methodol*. 2020;20:1–12.
23. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med*. 2018;169:467–73.
24. Abdool R, Szego M, Buchman D, Justason L, Bean S, Heesters A, et al. Difficult healthcare transitions: ethical analysis and policy recommendations for unrepresented patients. *Nurs Ethics*. 2015;23:770–83. <https://doi.org/10.1177/0969733015583185>.
25. Baetz-Dougan M, Reiter L, Quigley L, Grossman D. Enhancing care for long-term care residents approaching end-of-life: a mixed-methods study assessing a palliative care transfer form. *Am J Hosp Palliat Med*. 2021;38:1195–201.
26. Gorenko JA, Konnert C, Speirs C. Does caregiving influence planning for future aging?: A mixed methods study among caregivers in Canada. *Res Aging*. 2021;43:203–13.
27. Hainstock T, Cloutier D, Penning M. From home to 'home': Mapping the caregiver journey in the transition from home care into residential care. *J Aging Stud*. 2017;43:32–9.
28. King M, Steele Gray C, Kobewka D, Grudniewicz A. Continuity of care for older adults in a Canadian long-term care setting: a qualitative study. *BMC Health Serv Res*. 2022;22:1–11.
29. Oelke ND, Cunnings L, Andrews K, Martin D, MacKay A, Kuschminder K, et al. Organizing care across the continuum: primary care, specialty services, acute and long-term care. *Healthc Q*. 2009;13 Spec No:75–9.
30. Sloan JP, Buchanan B. Performance of the "house doctor". Effect of physician-to-patient ratio on follow up in long-term care facilities. *Can Fam Phys*. 1993;39:273.
31. Staykov E, Qureshi D, Scott M, Talarico R, Hsu AT, Howard M, et al. Do patients retain their family physicians after long-term care entry? A retrospective cohort study. *J Am Med Dir Assoc*. 2020;21:1951–7.
32. Casey L. \$400 fees, long-range patient transfers: What you need to know about Ontario's new long-term care rules. The Canadian Press; 2022. <https://www.cbc.ca/news/canada/toronto/ontario-long-term-care-patients-transfer-1.6583036>.
33. Halpern L, Phillips SD, Grasse NJ. Non-profit long-term care in Ontario: how financially robust is the system? *Can Public Policy*. 2022. https://doi.org/10.3138/CPP2022-032/ASSET/IMAGES/SMALL/CPP2022-032_F08.GIF.
34. MOHLTC. A guide to the long-term care homes act, 2007 and regulation 79/10. Ministry of Health and Long-Term Care. 2007.
35. Ljungholm L, Edin-Liljegren A, Ekstedt M, Klinga C. What is needed for continuity of care and how can we achieve it?—Perceptions among multiprofessionals on the chronic care trajectory. *BMC Health Serv Res*. 2022;22:1–15.
36. Davis MN, Smith ST, Tyler S. Improving transition and communication between acute care and long-term care: a system for better continuity of care. *Annals of Long Term Care*. 2005;13:25–32.
37. Groenvynck L, Fakha A, De Boer B, Hamers JPH, Van Achterberg T, Van Rossum E, et al. Interventions to improve the transition from home to a nursing home: a scoping review. *Gerontologist*. 2022;62:e369–83.
38. Lewanczuk R. Facilitating continuity of care at a health system level to support integration. *Int J Integr Care*. 2019;19:14.
39. Oliver D, Emili A, Chan D, Taniguchi A. Education in long-term care for family medicine residents. *Can Fam Physician*. 2011;57:e288–91.
40. Ong EY, Bower KJ, Ng L. Geriatric educational interventions for physicians training in non-geriatric specialties: a scoping review. *J Grad Med Educ*. 2021;13:654–65.
41. Dumont JC, Zurn P, Church J, LeThi C. International Mobility of Health Professionals and Health Workforce Management in Canada: Myths and Realities| OECD Health Working Papers| OECD iLibrary. 2008. <https://www.oecd-ilibrary.org/content/paper/228478636331>. Accessed 9 Aug 2024.
42. Ono T, Schoenstein M, Buchan J. Geographic imbalances in the distribution of doctors and health care services in OECD countries. *Health Workforce Policies in OECD Countries: Right Jobs, Right Kills, Right Places OECD Health Policy Studies*. 2016;129:161. https://www.oecd.org/en/publications/health-workforce-policies-in-oecd-countries_9789264239517-en.html.
43. Yen W, Hodwitz K, Thakkar N, Athina M, Martimianakis T, Faulkner D. The influence of globalization on medical regulation: a descriptive analysis of international medical graduates registered through alternative licensure routes in Ontario. *Can Med Educ J*. 2016;7:e19.
44. Elma A, Nasser M, Yang L, Chang I, Bakker D, Grierson L. Medical education interventions influencing physician distribution into underserved communities: a scoping review. *Hum Resour Health*. 2022;20:31.
45. Grierson L, Elma A, Aggarwal M, Bakker D, Johnston N, Agarwal G. Understanding the influence of medical education on physician geographic disposition: a qualitative study of family physician perspectives in Canada. *J Eval Clin Pract*. 2023;29:1261–70.
46. Grierson L, Mercuri M, Elma A, Mahmud M, Bakker D, Johnston N, et al. Associations between education policies and the geographic disposition of family physicians: a retrospective observational study of McMaster University education data. *Adv Health Sci Educ*. 2024;29:641–57.

47. Wilkinson E, Coffman M, Petterson S, Jabbarpour Y. Gender differences in reported weekly work hours among family physicians. *J Am Board Fam Med*. 2020;33:653–4.
48. Steffler M, Chami N, Hill S, Beck G, Cooper SC, Dinniwell R, et al. Disparities in physician compensation by gender in Ontario, Canada. *JAMA Netw Open*. 2021;4:e2126107–e2126107.
49. Levy C, Epstein A, Landry LA, Kramer A, Harvell J, Liggins C. Physician practices in nursing homes: final report| ASPE. 2006. <https://aspe.hhs.gov/reports/physician-practices-nursing-homes-final-report-1>. Accessed 9 Aug 2024.
50. Hedden L, Barer ML, Cardiff K, McGrail KM, Law MR, Bourgeault IL. The implications of the feminization of the primary care physician workforce on service supply: a systematic review. *Hum Resour Health*. 2014;12:1–11.
51. Marchildon GP, Allin S, Merkur S. Canada: health system review. *Health Syst Transit*. 2020;22:1–194.
52. Rudoler D, Deber RB, Dass AR, Barnsley J, Glazier RH, Laporte A. Paying for primary care: The relationship between payment for primary care physicians and selection of patients based on case-mix (No. 160007). Canadian Centre for Health Economics; 2016. <https://www.canadiancentrefortheconomics.ca/wp-content/uploads/2016/07/Rudoler-et-al.pdf>.
53. Lange TC, Carpenter T, Zwicker J. Primary care physician compensation reform: a path for implementation. The School of Public Policy Publications; 2020. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3846589.
54. Kantarevic J, Kralj B. Physician payment contracts in the presence of moral hazard and adverse selection: the theory and its application in Ontario. *Health Econ*. 2016;25:1326–40.

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