Canadian Journal on Aging / La Revue canadienne du vieillissement

www.cambridge.org/cjg

Family Physicians' Perspectives on Informational Continuity during Patient Transitions into Long-Term Care: A Qualitative Descriptive Study

Augustine Chukwuebuka Okoh[1,2], Aimun Shah[3], Christine Lin[4], Paranshi Gupta[4], Naisha Dharia[3], Caroline Caswell[5], Henry Yu-Hin Siu[3], Michelle Howard[3], Amit Arya[6,7], Holly Odoardi[8], Keya Shah[3], Sarah Wojkowski[9] and Lawrence Grierson[3,10]

[1]School of Kinesiology and Health Science, York University, Canada; [2]Department of Health Research Methods, Evidence and Impact, McMaster University, Canada; [3]Department of Family Medicine, Faculty of Health Sciences, McMaster University, Canada; [4]Temerty Faculty of Medicine, University of Toronto, Canada; [5]Max Rady College of Medicine, University of Manitoba, Canada; [6]Division of Palliative Care, Department of Family and Community Medicine, University of Toronto, Canada; [7]Division of Palliative Care, Department of Family Medicine, McMaster University, Canada; [8]Department of Healthy and Safe Communities,City of Hamilton, Canada; [9]School of Rehabilitation Science, Faculty of Health Sciences, McMaster University, Canada and [10]MERIT Research Centre, Faculty of Health Sciences, McMaster University, Canada

Article

Cite this article: Okoh, A.C., Shah, A., Lin, C., Gupta, P., Dharia, N., Caswell, C., Siu, H.Y.-H., Howard, M., Arya, A., Odoardi, H., Shah, K., Wojkowski, S., & Grierson, L. (2026). Family Physicians' Perspectives on Informational Continuity during Patient Transitions into Long-Term Care: A Qualitative Descriptive Study. *Canadian Journal on Aging / La Revue canadienne du vieillissement*
https://doi.org/10.1017/S0714980826100889

Received: 03 July 2026 UTC
Accepted: 26 August 2026 UTC

Keywords:
aging; informational continuity; continuity of care; transition; long-term care; primary care

Mots clés:
vieillissement; Continuité informationnelle; Continuité des soins; Transition; Soins de longue durée; Soins primaires

Corresponding author:
La correspondance et les demandes de tirés-à-part doivent être adressées à : / Correspondence and requests for offprints should be sent to: Augustine Chukwuebuka Okoh, School of Kinesiology and Health Science, Faculty of Health, York University, 4700 Keele St, Toronto, ON M3J 1P3, Canada (aokoh@yorku.ca)

Abstract

Background: When older adults enter long-term care (LTC) and change physicians, comprehensive patient handoff notes are essential to mitigate discontinuity; however, how family physicians engage with information exchange during LTC transitions remains unclear.
Objective and methods: Twenty in-depth interviews were conducted with family physicians to explain their information exchange activities during LTC transactions, as well as barriers and enabling factors.
Findings: Handoff notes often contained minimal information, but some physicians maximized the form, provided additional documents, communicated directly with the receiving LTC team, and/or prepared families to transmit information on behalf of their loved one. Suboptimal information transfer was linked to systemic constraints associated with the physicians' practice capacity, but also to their personal perceptions of the value of the information transmitted to LTC.
Discussion: The optimization of family physicians' ability to facilitate informational continuity during LTC transitions may require developing minimal standards for form completion, improving interprofessional collaboration during transitions, and improving LTC education experience during medical training.

Résumé

Context: Lorsque les personnes âgées intègrent des soins de longue durée (SLD) et changent de médecin, des notes de transmission complètes sont essentielles pour atténuer les ruptures de continuité des soins. Toutefois, la manière dont les médecins de famille participent à l'échange d'informations lors des transitions vers les SLD demeure mal comprise.
Objectif et méthodes: Vingt entretiens approfondis ont été menés auprès de médecins de famille afin de décrire leurs activités d'échange d'informations lors des transitions vers les SLD, ainsi que les obstacles et les facteurs facilitants associés à ces activités.
Résultats: Les notes de transmission contenaient souvent peu d'informations. Toutefois, certains médecins optimisaient l'utilisation du formulaire, fournissaient des documents supplémentaires, communiquaient directement avec l'équipe de SLD qui prenait en charge le patient et/ou préparaient les familles à transmettre des informations au nom de leur proche. Le transfert d'informations sous-optimal était associé à des contraintes systémiques liées à la capacité d'exercice des médecins, mais également à leurs perceptions personnelles de la valeur des informations transmises aux SLD.
Discussion: L'optimisation de la capacité des médecins de famille à assurer la continuité informationnelle lors des transitions vers les SLD pourrait nécessiter l'élaboration de normes minimales pour remplir les formulaires, une collaboration interprofessionnelle accrue durant les transitions ainsi qu'une amélioration de l'exposition à la formation sur les SLD au cours de la formation médicale.

© The Author(s), 2026. Published by Cambridge University Press on behalf of The Canadian Association on Gerontology. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (http://creativecommons.org/licenses/by/4.0), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

Introduction

Like most countries, Canada is experiencing a significant demographic shift, with individuals over 65 years old projected to increase from 16.9 to 22.7 per cent of the population between 2016 and 2031, and those over 85 increasing threefold by 2046 (CIHR, 2023; Statistics Canada, 2021). In Ontario, older adults over 75 years of age are estimated to double between 2017 and 2037 (CIHI, 2025). The rapidly growing senior population translates to increased demand for long-term care (LTC) beds.

Relational continuity refers to maintaining an ongoing patient-provider therapeutic relationship over a long period of time (Facchinetti et al., 2020). Research indicates that this type of continuity of care is linked to more effective prescribing, lower hospital admission and emergency department visit rates, reduced mortality, better therapy adherence, increased physician and patient satisfaction, enhanced preventive care, and lower health care costs (Barker et al., 2017; Chan et al., 2021; Te Winkel et al., 2023). The evidence underscores the value of patients maintaining a consistent relationship with a primary care provider, often a family physician, who understands their evolving health needs and personal circumstances. During transitions to LTC, however, over 87.9 per cent of older adults in Ontario with a family physician lose that relationship when entering an LTC home (Staykov et al., 2020). This is because most LTC homes in the province operate a 'closed' physician staffing model, where physicians employed by the home assume primary responsibility for the care of all their residents (Staykov et al., 2020). Ultimately, this means relational continuity of care is disrupted during LTC transitions.

The literature has examined the implications of a loss of relational continuity on health outcomes during transitions to LTC, highlighting higher rates of medical errors, sub-optimal care, rehospitalization, and mortality (King et al., 2022; Sloan & Buchanan, 1993; Staykov et al., 2020; Yun et al., 2024). These challenges may become increasingly pronounced as growing physician workloads and workforce shortages limit opportunities for direct communication and relationship building across care settings (Staykov et al., 2020). The rising demands across primary care and LTC systems limit opportunities for the strained physician workforce to maintain consistent therapeutic relationships during transitions.

To mitigate the impact of loss of relational continuity, informational continuity becomes essential for maintaining consistent and coherent care. This type of continuity reflects the efficient flow of comprehensive patient information across care settings. It implies sharing comprehensive information about patients' medical conditions, health histories, illness experiences, preferences, values, and circumstances when planning and implementing health care services as they move from one setting to another (Facchinetti et al., 2020; Haggerty et al., 2003). Informational continuity, in turn, aids management continuity – the maintenance of coherent care plans that are consistently responsive to the patients' changing needs across the continuum of care (Facchinetti et al., 2020).

Family physicians in Ontario engage with the LTC transition process, according to the tenets of the *Fixing Long-Term Care Act, 2021*, which requires them to fill out the Long-Term Care Health Assessment Form (LTC-HAF) when their patients move to LTC. This form aims to ensure that important patient information is received by the LTC providers (Government of Ontario, 2021; OH@H, 2024). While the policy mandates the transmission of the LTC-HAF, it does not detail minimal standards for completion, nor does it mandate direct communication (written or verbal) between the discharging (primary care) and accepting (LTC) care providers during the transition process. Research evidence from this domain indicates that family physicians, especially those practicing in urban areas, are rarely involved in such bidirectional communication (Okoh et al., 2025).

Qualitative case study research of LTC homes in Ontario suggests that the information family physicians transmit to LTC is regularly limited to brief descriptions of diagnosis, allergies, medications, and medical history without rich description of the relevant health history and patient preferences that have been determined through the longitudinal patient–family physician relationship (Okoh et al., 2026). However, to date, there is little understanding of the opinions, experiences, or constraints that influence how family physicians engage in sending information to LTC homes. Understanding their perspectives may shed light on why the information received by LTC teams is minimized and often insufficient, providing a pathway to recommendations for improved processes. Accordingly, the current study examines the information exchange process from the family physician perspective, seeking a description of the information they believe is important, the information they provide, how they provide it, and the factors that influence their information sharing decisions. This study supports the overarching goal of developing improved communication and information exchange during patient transitions into LTC.

Methods

We used a qualitative descriptive design (Sandelowski, 2010), detailing the experiences and perspectives of the patient-discharging family physicians. Qualitative description focuses on eliciting, describing, and representing participants' perspectives about the phenomenon of interest. It stays close to the data and offers low-inference interpretation.

Theoretical framework

This study was guided by a recently developed conceptual framework for continuity of care during LTC transition (Okoh et al., 2025). The framework integrates the perspectives of *Transitions Theory* and *Transdisciplinarity*. While *Transitions Theory* illuminates the roles of various actors and the influence of practice environments in a patient's transition (Meleis, 2015), *Transdisciplinarity* espouses specifically the collaboration of formal (and informal) care providers in care delivery (Okoh et al., 2020). The conceptual framework contemplates three broad factors that influence continuity of care during LTC transitions: stakeholder engagement (level of involvement of patients, partners-in-care, and interprofessional care team), practice features (influence of remunerative model, staffing model, and practice location), and physician characteristics (professional interest, previous experiences) (Okoh et al., 2025). This framework informed all stages of the study, including the development of our interview guide and data analysis.

The *Sociomateriality Theory* also served as a complementary theory for this work. It underscores the complex and dynamic relationship between materiality and social practices in shaping organizational practices and outcomes (Haider & Sundin, 2023; Kim & Yang, 2020). The theory argues that the manifest behaviours of actors and organizational practices are a result of the interactions between material and social elements constantly co-constituting

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press

each other (Haider & Sundin, 2023). The material elements are perceived as not just passive tools but as actively shaping and being shaped by actors' practices (Leonardi, 2013; Moura & Bispo, 2020). Thus, the sociomaterialist perspective helps us to make sense of the role of technology and other material objects in organizational life, and how these objects are shaped by the organizations' social and cultural factors (Fenwick, 2014; Moura & Bispo, 2020).

Recruitment

We purposefully recruited family physicians with a continuity-based community primary care practice in Ontario between July 9, 2024, and April 4, 2025. They were invited through advertisements circulated by the Greater Hamilton Health Network, co-investigators' (LG, HS, and MH) professional networks, and social media (LinkedIn and X [twitter]). We also leveraged snowballing techniques as participants were asked to share study details with colleagues whom they believed could offer insight on the topic. We aimed to recruit participants who varied with respect to their geographic location (rural, suburban, and urban), remuneration model (fee-for-service, salary, capitation, and blended), and career stage (early career [≤5 years], established [>5 years]).

Data collection

Each participant was invited for a one-hour, audio-recorded, individual interview conducted via Zoom video conferencing by the principal author (ACO, a man-identifying doctoral student). The semi-structured interview guide was developed, piloted, and refined by the full research team. It inquired about family physicians' perspectives on the value of care continuity, the information they transmit and would like to transmit to LTC, the strategies they employ to promote informational continuity, and their perceptions of facilitators and barriers to engaging in activities that support informational continuity during the LTC transition process. Adopting a transdisciplinary practice lens, we sought to elicit family physicians' thoughts on the utility of incorporating inputs from patients, other health care professionals, and partners-in-care such as family caregivers and support workers. We transcribed and deidentified the interviews before analysis.

Data analysis

Data were analysed using an unconstrained deductive approach (Elo & Kyngäs, 2008), which allows us to reflect our analysis of interviews through the lens of the LTC transitions-continuity of care conceptual framework (Okoh et al., 2025) while also capturing notions of analytic interest not contemplated by the framework. We constantly reflected on the interplay of stakeholder engagement, practice features, and physician characteristics in shaping participants' approach to information sharing during LTC transitions. Data were managed in NVivo15 (Lumivero LLC, Colorado).

The coding framework was developed by ACO through a preliminary analysis of three transcripts and tested by AS and LG. Six authors carried out the coding process, ensuring that each transcript was double-coded. The coders were a man-identifying doctoral student (ACO), a woman-identifying research coordinator with a bachelor's-level degree in health sciences (AS), and four women-identifying undergraduate-level student research assistants in a health sciences program (CL, ND, PG, and CC). All coders analysed two initial transcripts and discussed the process and their reflections before distributing the transcripts for double coding. Disagreements between coders were resolved by a third coder (ACO or LG). The analytic process involved focused coding and aggregation of top-level codes to create thematic categories from an iterative review of the data (Doyle et al., 2020; Vaismoradi et al., 2013). Findings were regularly shared with the full research team, who offered feedback to enhance credibility and ensure relevance to the policy context. Data collection and analysis ceased at the point of data sufficiency, when no new information arose from more interviews (Saunders et al., 2018). To enhance rigour, we kept interview memos which allowed us to provide interpretation to each participant's transcript during data analysis. Reflexive journals were kept during analysis to check and minimize the influence of our biases, beliefs, and personal experiences on the analysis and interpretation of results (Dodgson, 2019).

Results

We interviewed 13 participants who varied across sociodemographic, career stage, and practice characteristics (Table 1).

All study participants felt that they had a moral duty to facilitate the provision of good-quality care to older adults. In this regard, participants affirmed that they valued continuity of care for patients when they transition from one care setting to another. Although they would prefer to remain the most responsible physician for their patients, this was not often feasible in the context of their other professional responsibilities. For instance, Participant 2 said:

> I can see four more people at the same time it would take me to go there … Travel takes time… It doesn't really make sense for us to leave the clinic for efficiency purposes and monetary purposes and life purposes.

Table 1. Participants' demographic characteristics (n = 13)

Demographic characteristics	
Age (years)	44.1 (±10.4)
Gender	
Men	5 (38.5%)
Women	8 (61.5%)
Career stage	
Early career (≤5 years)	3 (23.1%)
Established (>5 years)	10 (76.9%)
Remuneration model	
Fee-for-service	1 (7.7%)
Capitation	7 (53.8%)
Salary	2 (15.4%)
Blended	3 (23.1%)
Practice location	
Urban	7 (53.8%)
Suburban	3 (23.1%)
Rural	3 (23.1%)
LTC practice experience	
Yes	5 (38.5%)
No	8 (61.5%)

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press

Accordingly, participants embraced informational continuity as a viable surrogate for relational continuity. The information that participants felt should be transmitted in support of informational continuity cut across both biomedical and psychosocial categories. They believed biomedical information pertaining to medical history, medical conditions, surgeries, allergies, sensitivities or adverse effects experienced with any drugs, use of oxygen, resistant organisms screening, chest x-rays, Tuberculosis skin tests, immunizations (last flu shot, tetanus, pneumococcal), physical functional abilities, mobility aids, incontinence products, and advance care plans (e.g., 'do not resuscitate' instructions) was valuable to support informational continuity of care. With respect to the psychosocial domain, they believed information about cognitive function, behavioural issues like wandering and aggression, family and social background, addictions, mental health and trauma history, hobbies, habits, and spiritual and cultural practices was important.

The information family physicians transfer

Our participants shared that they rarely communicated all of the abovementioned information to LTC providers during transitions. They indicated that the biomedical information was often limited to a brief medical history, current medical diagnoses, infectious disease assessments, current medications, and allergies. The psychosocial information was reduced to an even greater degree and was usually limited to safety concerns (e.g., wandering behaviours). They would include summaries of recent discharges from hospital or surgeries in the sent documents depending on the patient and availability of the information.

The data revealed several justifications for sub-optimal information exchange, including prevailing concerns about information redundancy or obsolescence, efforts to support efficient LTC placement for patients with aggressive behaviours, the material limits of the LTC-HAF documents, and current completion standards.

The information is not actually all that valuable

Despite generally affirming the value of informational continuity of care, this was not always reflected in practice. Our data reveals a tension pertaining to balancing the desire to provide comprehensive information with the perceived utility of the transmitted information.

Many participants expressed uncertainty that the LTC providers use the information they provide. This was seen as demotivating the provision of a more comprehensive information transfer. For instance, there were concerns that the LTC-HAF may be a duplicative activity:

> I feel like when somebody goes into long-term care, they have a full assessment that needs to be done within a certain timeframe after they come into the care home. So, a lot of the time, the physician working in the long-term care home is gathering their own information. (Participant 4)

Furthermore, participants were also sceptical about the utility of the information they provided because it does not always capture changes in patients' health over time:

> I think probably the part that I struggled most as a physician to complete is just that piece about what the patient is and isn't able to do on their own … To get into long-term care, depending on their triage, can be like months to a year. I don't know about their functioning when I'm filling out that form compared to when I requested that they be considered for long-term care. (Participant 7)

Interestingly, several participants suggested that their professional scope also limited their ability to provide comprehensive biopsychosocial information that supports care continuity. These individuals opined that appropriately holistic information exchange should include inputs from the interprofessional collection of care providers involved in the patient's care, but that the LTC-HAF was the exclusive responsibility of the family physician:

> The care coordinator should be taking our opinion and combining that with OT [occupational therapy] and PT [physiotherapy] and speech language pathology, and whoever else needs to be involved… and then transmit that to the long-term care home the patient applied for. (Participant 5)

Comprehensive information exchange is not always in the patient's best interest

A few participants highlighted that the system of allocation of LTC spots in Ontario promotes implicitly the withholding of psychosocial information that may influence LTC placement decisions. This was most prominently discussed with respect to patients who demonstrate aggressive or socially problematic behaviours. In these circumstances, the family physician may choose to not include this information in order to encourage their welcome into the home:

> He had been extremely physically aggressive, and so I had put that in a documentation only to get a call to tell me that I should not put this in because they won't take him. And I thought that was strange because it's better to let them know what is going on. I put in what I could, and it took longer for the family to get a home placement. (Participant 1)

The LTC-HAF is a limited document

Notably, most participants pointed to the material limits of the LTC-HAF as major drivers of their decision to provide less than optimal information. Specifically, they noted that the structure of LTC-HAF accommodates only a limited selection of information. It does not offer enough space to provide a more detailed patient history nor prompts to include some diagnostic information or psychosocial information (e.g., spiritual or cultural practices). In this regard, one participant said:

> [T]he way the information is asked for results in less information being given as opposed to more. So, for example, if I fill out an insurance form, they'll often ask for consultant's notes or imaging results… I don't remember seeing specific requests for that kind of information on admission to nursing home form. (Participant 3)

Augmenting this, participants also pointed out that there are no clear standards or thresholds for the minimal information family physicians should include in the LTC-HAF. Indeed, we heard that the LTC-HAF is usually accepted regardless of any missing information or any space that was left blank. Hence, they would often leave sections blank when the relevant information was not readily available: 'If I have it in my chart, I'll send it. If I don't have it, I just leave it blank' (Participant 4).

When more information exchange is deemed necessary

To offer more information, almost all the participants said that the LTC-HAF is frequently sent along with the cumulative patient profile (CPP). The CPP is a structured summary of the patient's medical history and current health information, which is contained in each practice's electronic health record. A typical version of the CPP contains personal information, family history, current

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press

problem, history of past health, current medication/treatment, allergies, immunizations, and risk factors.

The CPP is not a mandatory document; the LTC-HAF is the only mandatory document family physicians are required to send. Because the LTC-HAF is inadequate or may not prompt all the information they would like to send to LTC, participants said that they often choose to include the CPP. However, they also highlighted that including this document is also not necessarily sufficient to fully achieve informational continuity because it contains little psychosocial information beyond family history.

While all participants shared a sense that the information prompted by the LTC-HAF and the CPP was often sub-optimal, a few described extending their efforts so as to provide the LTC care team with more information. Some of these participants described appending additional notes pertaining to the patient's condition: 'In addition to providing the CPP [cumulative patient profile], I include a bit of a narrative on what has happened recently and what's really caused the change to require long-term care' (Participant 1). While others described engaging in direct communication with the LTC providers: '[T]he handover to the physician, if that doctor is in the hospital for the week, it could literally be face to face' (Participant 9). Notably, all participants – whether they participated in direct provider–provider communication – asserted a belief that this practice would enhance informational continuity and ensure greater and clearer information exchange.

The most common strategy described by participants who went beyond the completion of the LTC-HAF and CPP, however, was to prepare the patient's family members and caregivers to be able to present information about their loved one to the LTC team during and following the transition:

> I find the best way to do it is to really educate the caregiver, whoever is going to be their main contact… and you just be very open with all the diagnoses, all the stuff that's going on, all their medications, why they're on it. That's how you have the safest transition realistically, because it's not me that's talking to the long-term care people, it's the family that ends up talking to the long-term care people. (Participant 2)

Factors that influence family physician decisions to provide more or less information

A relatively small proportion of our participants described providing more information than prompted by the LTC-HAF. Despite this, we were able to identify within their descriptions some common factors that bore relevance on their decision to do so or not do so.

Practice capacity and fee-for-service remuneration

Most prominently, the decision to not go beyond the form was universally couched in the capacity required to meet all the needs of a practice. Family physicians grapple with balancing their time across direct patient care and a growing amount of paperwork. With this in mind, our participants regularly described that they did not have adequate time to 'add in' more than is minimally required:

> Ideally, a physician shouldn't have a full 8h clinic with patients and then have one million forms like this to fill out … If you want the most fulsome history and information to go to the long-term care home to support the patient's ongoing continued good care, it needs to be resourced, right? (Participant 7)

These descriptions of time allocation were almost universally tied to the remunerative model that defined the practice. Specifically, participants working under fee-for-service remuneration were unlikely to allocate much time to administrative services because of the opportunity cost of providing direct patient care services with higher compensation:

> …pure fee-for-service disincentivizes people from doing this… takes a long time, and they could be seeing other people… If you're a salaried doc[tor], truthfully, it doesn't matter to you, either way you're getting paid to do the work. (Participant 9)

Rurality and urbanicity

Our data also showed that information-exchange behaviours differed across rural and urban contexts. Notable, in this regard, was that participants in rural settings were more likely to extend their efforts toward informational continuity because they work across acute care, primary care, and LTC in their regions. The *tight knit* health care arrangements in the rural areas facilitated easy direct provider-to-provider communication with LTC physicians during transitions. Often the physicians receiving the patients within LTC were described as members of the participants' group family practice or someone they know quite well:

> We're really privileged from the point of view that all the primary care providers in this whole area work under one roof. So, those doctors who are at long-term care, if they're not currently working in my clinic, they used to… they don't just get the form in the discharge summary… So, there's a warm handover, whether it's a phone call or direct face-to-face because we're sitting in the same office. (Participant 9)

On the other hand, the participants working in urban and suburban areas described that it was rare for them to getting involved in such bidirectional communication, although they affirmed that they value the opportunity for direct provider–provider communication when possible:

> I think that would be valuable, and I've had an experience where a physician that I knew was taking over the care of somebody. And so, we got to actually have a conversation and that made me feel like that patient was probably going to get a little bit of a smoother transition in care. (Participant 8)

Previous experience working in LTC

We heard that LTC practice experiences and/or immersive educational experiences in LTC also influenced the participants' approach to LTC transitions. Specifically, participants with those experiences were more inclined to go beyond the LTC-HAF to ensure informational continuity for their patients:

> I worked for 13 years in long-term care… and obviously I can't have the same relationship continuity when my patients go into long term care now. But I do feel I have an obligation and a role to play to provide good informational continuity. (Participant 11)

Discussion

Our findings provide insight into family physicians' perceptions of and engagement with information sharing during the LTC transition process. While participants acknowledged the LTC-HAF as an essential document, they expressed concerns regarding its limitations and the time they had available to complete it. These concerns

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press

track closely with the outcomes of a survey study that revealed care providers' preference for efficient interoperable, computerized documentation that saves time and improves the amount of patient-relevant information provided (Tuohy et al., 2021). Furthermore, the lack of clear minimum information standards associated with the document may lead to practitioners providing less than comprehensive information (Griffiths et al., 2014). Indeed, research shows that information standards promote optimized information transmission during care transitions (Thraen et al., 2012; Tuohy et al., 2021).

Since the LTC-HAF was perceived as inadequate to achieve informational continuity, some of our study participants resorted to providing extra documents (CPP and narrative summary), educating family caregivers or communicating directly with the LTC team; although, these efforts were inconsistently described. Notably, they were common among individuals with a previous LTC education and practice, highlighting the pivotal influence of these experiences on family physician's disposition to support informational continuity. This corroborates several studies showing that LTC experience during training is associated with physician's preparedness for continuity-based practice (Oliver et al., 2011; Ong et al., 2021; Staykov et al., 2020).

The finding also revealed that some physicians intentionally withhold or downplay negative information, such as a patient's history of physically aggressive behaviour. This highlights a profound ethical tension between individual patient advocacy and the collective responsibility to ensure safe, appropriate care within LTC settings. On one hand, physicians may perceive selective disclosure as an act of advocacy, particularly when prolonged hospitalization exposes patients to risks such as functional decline, hospital-acquired complications, or social isolation (Chan et al., 2021; Te Winkel et al., 2023). From this perspective, securing an LTC bed quickly may appear to serve the patient's best interests.

Yet, withholding clinically relevant behavioural information shifts risk onto receiving LTC facilities, where staff may be inadequately prepared to implement appropriate behavioural management strategies, and other residents may be exposed to preventable harm. This practice also undermines the ethical principles of transparency and justice by compromising equitable risk sharing across health care sectors. Beyond its ethical implications, incomplete or inaccurate information transfer may directly compromise the quality and continuity of medical care (Yun & Bickmore, 2025). LTC teams rely on comprehensive clinical information to develop individualized care plans, allocate staffing resources, and anticipate behavioural or medical needs (Okoh et al., 2026). Missing critical information can delay appropriate interventions, contribute to adverse events, and increase the likelihood of early emergency department transfers or rehospitalization (Yun et al., 2024; Yun & Bickmore, 2025), thereby negating the intended benefits of timely placement. These findings underscore the need for standardized transfer protocols, accountability mechanisms, and policies that link incentives with accurate information exchange rather than rapid LTC placement alone.

However, the findings show that remunerative models could impose constraints and incentives to practice behaviour. For instance, fee-for-service physicians were less likely to allocate time to paperwork, whereas salaried physicians described fewer practice-level barriers in completing the LTC-HAF. The literature corroborates this finding also, showing that the fee-for-service remuneration model is associated with reduced time allocation to indirect care services, such as paperwork and more time allocation to care activities that are incentivized financially (Clay, 2020; Devoe, 2020; Kantarevic & Kralj, 2016; Kraft et al., 2024). In principle, a major drawback of the fee-for-service model is the oversupply of high-paying services, irrespective of the likelihood to improve outcomes, whereas as of low-paying, undervalued services that are essential to the health and wellbeing of a given population may be undersupplied or neglected (Devoe, 2020; Kantarevic & Kralj, 2016). However, nuances exist – not all physicians respond to financial incentives uniformly because professional ethics, patient relationships, and institutional norms modulate behaviour. For instance, the American Medical Association's Code of Medical Ethics clearly states that physicians must never prioritize their financial interests over the well-being of their patients. Physicians who uphold such ethical codes are unlikely to intentionally modify their practice decisions based on financial incentives (Mitchell et al., 2019; Robertson et al., 2012).

This collection of results is evocative of the *Sociomateriality Theory*. The theory draws our attention to the roles of material objects (e.g., LTC-HAF, EHR), immaterial constructs (e.g., policies, guidelines), and social elements (e.g., organizational practices and outcomes) in shaping family physicians' practice behaviour during the LTC transition process. For instance, the family physician's tendency to provide minimal information is not simply the result of personal decisions or values but also reflects their interactions with the LTC-HAF's design and the surrounding guidelines (Fenwick, 2014; Haider & Sundin, 2023). An improved system needs to consider not only a refined form but also how organizational and social factors influence how the family physician will interact with it (Kim & Yang, 2020). A clear example of this influence appears in the study findings that highlight how the close professional relationships in rural contexts support greater information exchange.

Implications for practice, education, and policy

The current study fills a gap in the literature on continuity of care, particularly pertaining to informational continuity during LTC transitions in Ontario. Uncovering the limits of the current document-based handoff has highlighted a need for other complementary communication strategies. Inconsistencies in the information provided in the documents underscore the necessity of a clear standard for comprehensive information transfer during these transitions. Noting the limits of family physicians' professional boundaries, we infer that an interprofessional approach to completing the LTC transition documentation may be necessary.

Accordingly, we recommend some strategies to enhance informational continuity during LTC transitions. First, in Ontario, the LTC-HAF is currently paper-based and not interoperable with primary care EHRs. Integrating the LTC-HAF with EHRs could streamline information sharing and reduce redundancy. Making it digital and interoperable would allow auto-population from EHRs, thereby saving time and improving efficiency.

Second, we recommend integrating educational content on LTC into undergraduate and postgraduate medical training curricula to ensure practitioners gain experience and competencies related to LTC and, in turn, develop an understanding of the importance of good informational continuity. With a projected rapid increase in the older adult population and a growing number of individuals who need LTC, medical education at all levels should pay more attention to the care of this demographic.

Third, expanding interdisciplinary involvement in care transitions by incorporating input from the full range of health professionals could support a more holistic approach to informational continuity of care. This could mitigate constraints associated with

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press

physicians' practice capacity, as participants noted that they may not provide information that is beyond the boundaries of their scope of practice. Hence, other health care professionals who may be more qualified to provide certain information (e.g., assistive devices) could contribute to the documentation. While geographic distance, high workloads, and time constraints may hamper the feasibility of family physicians and other care providers working collaboratively to generate comprehensive biopsychosocial information, a care coordinator from the regional health authority may be deployed to manage the collection and collation of information from various providers.

Lastly, operationalizing a standardized protocol for provider–provider communication – through remunerated and structured phone or videoconferencing calls – could enhance the transfer of critical patient care insights from family physicians to LTC providers. For instance, Ontario has insured billing codes for LTC case conferences with multiple health care professionals (K124) to discuss a patient's care plan and progress while in an LTC home, as well as physician-to-physician telephone consultations (K730) and e-consultations (K738) for the primary care physicians to collect data that are not already available in their records (OMA, 2025). However, there is no available billing code for primary care physicians and LTC providers for information sharing during LTC transitions. Aligning financial incentives with care continuity-targeted services may encourage family physicians to allocate time for comprehensive information transfer.

Limitations

Given challenges with recruiting family physicians, we completed only 13 interviews. While the relatively small sample size may limit the generalizability of the findings, we achieved representation across a range of participant characteristics, including gender, age, career stage, LTC experience, and rurality, thereby supporting the theoretical generalization of our findings. However, we acknowledge that data saturation may not have been fully achieved within specific demographic groups or sub-groups, and as such, potential differences across these groups should be interpreted with caution. Likewise, participants' race, ethnicity, or cultural background was not collected. Future research with larger and more diverse samples is needed to validate these distinctions and further explore sub-group-specific experiences. Nonetheless, the contextually rich findings provide valuable insights into family physicians' current practices and perceived barriers to informational continuity during LTC transitions within the study jurisdiction.

Conclusion

Informational continuity is important in ensuring high-quality care during LTC transitions. While the LTC-HAF serves as a foundational tool, additional approaches such as appending additional documents, inter-provider communication, and preparing caregivers with transitional care information could aid in optimizing informational continuity during these transitions. Addressing constraints that shape their family physicians' information-exchange behaviour (e.g., perceived utility of the information, remuneration, and time constraints) would bolster their ability to engage in activities that support informational continuity. Also, considering technological barriers related to completing the LTC-HAF and a fragmented electronic information system that family physicians face, future research could explore the implementation of digital solutions to enhance the efficiency and comprehensiveness of information transfer during LTC transitions.

Data availability statement. The dataset generated and analysed during the current study is not publicly available because individuals' privacy could be compromised, but it is available from the corresponding author upon reasonable request.

Acknowledgements. We would like to express our gratitude to Dr. Ellen Badone for the immense contribution to various stages of the research, including design, execution, and report development. We greatly appreciate McMaster Institute for Research on Aging, Greater Hamilton Health Network Long Term Care Advisory, and Ontario Long Term Care Clinicians for their invaluable support for this research project. We are deeply appreciative of their collaboration and commitment to advancing the field of aging and research on long-term care.

Author contribution. A.C.O. and L.G. contributed to the design of the work. A.C.O., A.S., C.L., P.G., N.D., C.C. and L.G. contributed to the analysis and interpretation of data. A.C.O. and A.S. performed the data collection, and A.C.O. drafted the manuscript. A.C.O., H.Y.-H.S., M.H., A.A., K.S., and L.G. critically revised the article. All the authors approved the final manuscript.

Financial support. HS, LG, ACO, MH, and EB are joint recipients of the Health Service Research award from the Physicians' Services Incorporated Foundation (#24-16). Also, ACO received generous support from the Department of Family Medicine, McMaster University, through the Pilot Research Project Funding.

Competing interests. The authors declare no competing interests.

Ethics approval. Ethics approval was obtained through the Hamilton Integrated Research Ethics Board (#16209), and all participants completed a written informed consent form before enrolment in accordance with the guidelines set forth by the Declaration of Helsinki (2024).

Consent for publication. Not applicable.

References

Barker, I., Steventon, A., & Deeny, S. R. (2017). 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 (Online)*, **356**. https://doi.org/10.1136/bmj.j84

Chan, K. S., Wan, E. Y. F., Chin, W. Y., Cheng, W. H. G., Ho, M. K., Yu, E. Y. T., & Lam, C. L. K. (2021). Effects of continuity of care on health outcomes among patients with diabetes mellitus and/or hypertension: A systematic review. *BMC Family Practice*, **22**(1), 145. https://doi.org/10.1186/s12875-021-01493-x

CIHI. (2025). *Infographic: Canada's seniors population outlook: Uncharted territory.* https://www.cihi.ca/en/infographic-canadas-seniors-population-outlook-uncharted-territory

CIHR. (2023). *CIHR Institute of aging strategic plan 2023–2028. Reframing aging – empowering older adults.* https://cihr-irsc.gc.ca/e/46837.html

Clay, Z. (2020). The shift to fee-for-service: Neoliberalism and behavioral health services. *Reflections: Narratives of Professional Helping*, **26**(1), 75–85. https://reflectionsnarrativesofprofessionalhelping.org/index.php/Reflections/article/view/1685/1603

Devoe, J. E. (2020). The incompatibility of patient-centered care with fee-for-service payment. *JAMA Internal Medicine*, **180**(12), 1572–1573. https://doi.org/10.1001/JAMAINTERNMED.2020.4341

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, **35**(2), 220–222. https://doi.org/10.1177/0890334419830990

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, **25**(5), 443–455. https://doi.org/10.1177/1744987119880234

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, **62**(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Facchinetti, G., D'Angelo, D., Piredda, M., Petitti, T., Matarese, M., Oliveti, A., & De Marinis, M. G. (2020). Continuity of care interventions for preventing hospital readmission of older people with chronic diseases: A meta-analysis. *International Journal of Nursing Studies*, **101**, 103396. https://doi.org/10.1016/j.ijnurstu.2019.103396

Fenwick, T. (2014). Sociomateriality in medical practice and learning: Attuning to what matters. *Medical Education*, **48**(1), 44–52. https://doi.org/10.1111/MEDU.12295

Government of Ontario. (2021). *Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1.* https://www.ontario.ca/laws/statute/21f39

Griffiths, D., Morphet, J., Innes, K., Crawford, K., & Williams, A. (2014). Communication between residential aged care facilities and the emergency department: A review of the literature. *International Journal of Nursing Studies*, **51**(11), 1517–1523. https://doi.org/10.1016/J.IJNURSTU.2014.06.002

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *British Medical Journal*, **327**(7425), 1219–1221. https://doi.org/10.1136/bmj.327.7425.1219

Haider, J., & Sundin, O. (2023). Sociomateriality. In A. Hicks, A. Loyd, & O. Pilerot (Eds.), *Information literacy through theory. Facet publishing*. Facet. https://doi.org/10.29085/9781783305919.010; https://portal.research.lu.se/en/publications/sociomateriality

Kantarevic, J., & Kralj, B. (2016). Physician payment contracts in the presence of moral Hazard and adverse selection: The theory and its application in Ontario. *Health Economics*, **25**(10), 1326–1340. https://doi.org/10.1002/HEC.3220

Kim, Y., & Yang, E. (2020). Theoretical understanding of sociomateriality in workplace studies. *Facilities*, **38**(13/14), 927–942. https://doi.org/10.1108/F-10-2019-0112

King, M., Steele Gray, C., Kobewka, D., & Grudniewicz, A. (2022). Continuity of care for older adults in a Canadian long-term care setting: A qualitative study. *BMC Health Services Research*, **22**(1), 1–11. https://doi.org/10.1186/S12913-022-08583-1/TABLES/3

Kraft, K. B., Hoff, E. H., Nylenna, M., Moe, C. F., Mykletun, A., & Østby, K. (2024). Time is money: General practitioners' reflections on the fee-for-service system. *BMC Health Services Research*, **24**(1), 1–10. https://doi.org/10.1186/S12913-024-10968-3/FIGURES/1

Leonardi, P. M. (2013). Theoretical foundations for the study of sociomateriality. *Information and Organization*, **23**(2), 59–76. https://doi.org/10.1016/J.INFOANDORG.2013.02.002

Meleis, A. I. (2015). Transitions theory. *Nursing theories and nursing practice*, **4**, 361–380. https://www.springerpub.com/transitions-theory-9780826105349.html

Mitchell, A. P., Rotter, J. S., Patel, E., Richardson, D., Wheeler, S. B., Basch, E., & Goldstein, D. A. (2019). Association between reimbursement incentives and physician practice in oncology. *JAMA Oncology*, **5**(6), 893–899. https://doi.org/10.1001/jamaoncol.2018.6196

Moura, E. O. d., & Bispo, M. d. S. (2020). Sociomateriality: Theories, methodology, and practice. *Canadian Journal of Administrative Sciences / Revue Canadienne des Sciences de l'Administration*, **37**(3), 350–365. https://doi.org/10.1002/CJAS.1548

OH@H. (2024). *Guide to placement in long-term care homes.* https://healthcareathome.ca/document/guide-to-placement-in-long-term-care-homes/

Okoh, A. C., Shah, A., Lin, C., Gupta, P., Dharia, N., Caswell, C., Siu, H. Y.-H., Howard, M., Arya, A., Odoardi, H., McKenna, B., Shah, K., Wojkowski, S., & Grierson, L. (2026). Long-term care providers' perspectives on health information exchange during patient transitions into long-term care: A multiple case study. *Healthcare Management Forum*, **39**(4), 366–372. https://doi.org/10.1177/08404704261426444

Okoh, A. C., Shahu, A., Gu, R., Siu, H., Howard, M., Badone, E., & Grierson, L. (2025). Continuity of care during long-term care transitions: A scoping review of the Canadian literature. *BMC Health Services Research*, **25**(1), 606–613. https://doi.org/10.1186/S12913-025-12558-3

Okoh, A. E., Akinrolie, O., Bell-Gam, H. I., Adandom, I., Ibekaku, M. C., & Kalu, M. E. (2020). Nigerian healthcare workers' perception of transdisciplinary approach to older adults' care: A qualitative case study. *International Journal of Care Coordination*, **23**(2–3), 92–106. https://doi.org/10.1177/2053434520954362

Oliver, D., Emili, A., Chan, D., & Taniguchi, A. (2011). Education in long-term care for family medicine residents: Description of an integrated program. *Canadian Family Physician*, **57**(8), e288–e291. https://www.cfp.ca/content/57/8/e288

OMA. (2025). *Access OHIP billing codes and forms fast.* https://www.oma.org/practice-professional-support/billing-and-payments/ohip-billing/

Ong, E. Y., Bower, K. J., & Ng, L. (2021). Geriatric educational interventions for physicians training in non-geriatric specialties: A scoping review. *Journal of Graduate Medical Education*, **13**(5), 654–665. https://doi.org/10.4300/JGME-D-20-01484.1

Robertson, C., Rose, S., & Kesselheim, A. S. (2012). Effect of financial relationships on the Behaviors of health care professionals: A review of the evidence. *Journal of Law, Medicine & Ethics*, **40**(3), 452–466. https://doi.org/10.1111/j.1748-720x.2012.00678.x

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health*, **33**(1), 77–84. https://doi.org/10.1002/nur.20362

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, **52**(4), 1893–1907. https://doi.org/10.1007/S11135-017-0574-8

Sloan, J. P., & Buchanan, B. (1993). Performance of the "house doctor". Effect of physician-to-patient ratio on follow up in long-term care facilities. *Canadian Family Physician*, **39**, 273–273.

Statistics Canada. (2021, July 1). *The Daily—Canada's population estimates: Age and sex.* https://www150.statcan.gc.ca/n1/daily-quotidien/210929/dq210929d-eng.htm

Staykov, E., Qureshi, D., Scott, M., Talarico, R., Hsu, A. T., Howard, M., Costa, A. P., Fung, C., Ip, M., Liddy, C., & Tanuseputro, P. (2020). Do patients retain their family physicians after long-term care entry? A retrospective cohort study. *Journal of the American Medical Directors Association*, **21**(12), 1951–1957. https://doi.org/10.1016/j.jamda.2020.04.016

Te Winkel, M. T., Damoiseaux-Volman, B. A., Abu-Hanna, A., Lissenberg-Witte, B. I., van Marum, R. J., Schers, H. J., Slottje, P., Uijen, A. A., Bont, J., & Maarsingh, O. R. (2023). Personal continuity and appropriate prescribing in primary care. *The Annals of Family Medicine*, **21**(4), 305–312. https://doi.org/10.1370/afm.2994

Thraen, I., Bair, B., Mullin, S., & Weir, C. R. (2012). Characterizing "information transfer" by using a joint cognitive systems model to improve continuity of care in the aged. *International Journal of Medical Informatics*, **81**(7), 435–441. https://doi.org/10.1016/j.ijmedinf.2011.11.006

Tuohy, D., Fahy, A., O'Doherty, J., Meskell, P., O'Reilly, P., O'Brien, B., Murphy, J., Doody, O., Graham, M., Barry, L., Kiely, M., O'Keeffe, J., Dewing, J., Lang, D., & Coffey, A. (2021). Towards the development of a national patient transfer document between residential and acute care—A pilot study. *International Journal of Older People Nursing*, **16**(4), e12374–e12374. https://doi.org/10.1111/OPN.12374

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, **15**(3), 398–405. https://doi.org/10.1111/nhs.12048

Yun, H., Unruh, M. A., Ryskina, K. L., & Jung, H.-Y. (2024). Association between discontinuity in clinicians and outcomes of nursing home residents. *Health Affairs Scholar*, **2**(11), qxae139. https://doi.org/10.1093/HASCHL/QXAE139

Yun, H. S., & Bickmore, T. (2025). Online health information–seeking in the era of large language models: Cross-sectional web-based survey study. *Journal of Medical Internet Research*, **27**, e68560. https://doi.org/10.2196/68560

https://doi.org/10.1017/S0714980826100889 Published online by Cambridge University Press