Francesco Carelli
francesco.carelli@alice.it

48 – Continuity of Care

Francesco Carelli
Professor, EURACT Council Executive Board,
BME Committee Chair, LJPC
International Editor

Continuity of care is a cornerstone of family medicine and a key point for patients.

It has been included by EURACT (European Academy of Teachers in General Practice and Family Medicine), in “Person-centred care”, and one of the “Core competences of GP/FM”(1), as the ability “to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and co-ordinated care management”. It can be interpreted as following the patient from birth (sometimes also before) until death (sometimes even after), throughout their whole life.

Continuity of care, also described as ‘the ability to manage in continuity of time, in the individual, a series of multiple complaints and pathologies, both acute and chronic health problems’ (3), enables doctors to promote health and well-being by applying health care and disease prevention strategies appropriately, as described in another core competence, the “Comprehensive Approach”.

It is firmly bound to other core competencies, in the “Holistic Approach” (considering a biopsychosocial model taking into account cultural and existential dimensions), and “Community Orientation” (also taking into account the community in which the individual patient lives and trying to reconcile health needs of both individual patient and community in balance with available resources).

With continuity of care, it is possible to adequately handle risk factors by promoting self-care and empowering patients.

The family doctor knows the community's potential and limitations, health needs, epidemiological characteristics, interrelationships between health and social care, impact of poverty, ethnicity, and inequalities in health care. He also needs to have an understanding of the structure of the health care system, with its economical limitations, the correct use of its services by patient and doctor (referral procedure, co-payments, sick leave, legal issues etc.) in their own context. All this is possible through provision of continuity of care by GP/Family Doctor.

The multiple dimensions of continuity

Fletcher et al. (3) distinguish between “coordination” as “the degree to which various components of care bear a useful relation to each other”, and “continuity” as “the existence of some thread - individual, practitioner, group, or medical record - that bind together episodes of care”. But the term ‘continuity of care’ has been used to describe a great variety of relationships between patients and the delivery of health care. (4)

Record Continuity refers to availability of all the information about a patient's history, visits, tests, allergies, medications, and preferences, in a medical record or clinical database, easily shared by all the clinicians caring for the patient, whether in the same institution, between institutions, or between care settings. This can improve

quality of care in the presence of increasing mobility of patients, increasing numbers of people involved in their care, and increasing amount of information to remember.

Clinician Continuity, highly appreciated by patients, refers to maintaining a relationship with the same doctor over time (5). In medical education literature, this use appears in family practice, general internal medicine, and paediatric journals.

Both record and clinician continuity are used in the definition of primary care that describe it as accessible, continuous, comprehensive, family centred, coordinated, and compassionate, delivered or directed by well-trained physicians, both able to manage or facilitate essentially all aspects of care and linked to the patient and family in a relationship of mutual responsibility and trust with them. Of course nobody can be available 24 hours/day, but a GP/FD can usually manage the care of a patient with occasional intervention of nurses or other colleagues, ward or emergency doctors, or specialists, when not present. In various surveys, patients showed a preference for single doctor practices, or multi-practice where they can see their own FD, even in limited hours, than for “Polyclinics” with rotas of doctors and 24/7 visiting hours.

Clinician continuity is thought to be important, in that not all information is included in the medical records, and a clinician who knows a patient can recognize significant changes, with a period of reference to go by (the patient as his/her own control). Behaviour and body language compared to patients’ previous visits may be as important as clinical findings in identifying a significant event.

A continuous relationship can promote trust, a core part of the clinician-patient relationship and possible part of the healing process. Trust and mutual respect facilitate patients divulging private information, or posing questions otherwise. This relationship is important not only to patients, but also to the clinicians, representing a valued part of medical practice.

Site Continuity means that patients have a "usual source of care" as opposed, for example, to unrelated emergency departments.

Continuity also appears in the literature as synonymous with accessibility or availability or even with compliance, such as following post-hospital discharge instructions or follow-up appointment keeping.

The Continuum of Care. In long-term care literature, continuity is used as a synonym for the continuum of care (7) which is defined as a client-oriented system composed of both services and integrating mechanisms that guides and tracks patients over time through a comprehensive array of health, mental health, and social services spanning all levels of intensity of care.

Continuity as an Attitudinal Contract. Finally, continuity has been described as a "contract of attitudes” (8). There is a “cornerstone caregiver” who is in charge of the patient's care and is the sole responsible for decisions and for communicating information to the patient and his or her family. If the previous uses of the term “continuity” could be considered retrospective (to what extent has it occurred), the attitudinal contract - whether called coordination, integration, or continuity - could be considered concurrent and prospective.

Continuity and Improved Outcomes of Care

Linking the degree of continuity, however defined, with improved clinical outcomes (e.g., for chronic problems, preventive care) has been reviewed by Starfield , concluding that continuity of care is “associated with more indicated preventive care, better identification of patients’ psychosocial problems, fewer hospitalizations (in emergency and in general), shorter lengths of stay, better compliance with appointments and taking of medications, and more timely care for problems”.

Take home messages

- Cornerstone of family medicine and key point for the patients.
- Present in core competences (person-centred; comprehensiveness, community orientation; holistic approach.
- Promotes health, well-being , empowering patients.
- Relationship with the same doctor over the time.

Original abstract

http://www.woncaeurope.org/content/bp21-continuity-general-practice

References

1. *EURACT Educational Agenda*, www.euract.eu
2. Starfield, B. *Primary Care: Concept, Evaluation, and Policy*. New York: Oxford University Press, 1992.
3. Fletcher, R.H., O'Malley, M.S., Fletcher, S.W., et al., Measuring Continuity and Coordination of Medical Care in a System Involving Multiple Providers. *Med Care* 22:403-411, 1984.
4. Kristjansson et al. Predictors of relational continuity in primary care: patient, provider and practice factors
5. Rivo, M.L., Saultz, J.W., Wartman, S. et al. Defining the Generalist Physician's Training. *JAMA* 271:1499-1504,1994.
6. Hayward, R.A. Regular Source of Ambulatory Care and Access to Health Services *AJPH* 81:434- 438,1991.
7. Evashwick, C.J. *The Continuum of Long-Term Care: An Integrated Systems Approach*. New York: Delmar, 1996.
8. Banahan, B.F., Jr. and Banahan, B.F., III. Continuity as an Attitudinal Contract. *J Fam Prac* 12:767-768, 1981.