Improving primary care

Continuity is about relationships

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The attributes of a high-performing primary care system are now well documented in the literature and include the following: access; continuity; team-based care that is comprehensive and whole-person centred; creation of population-focused accountability; coordination and service integration; and patient engagement.[1-4] We see it as problematic to isolate any of these attributes from the others. However, it has been our observation that continuity, particularly relational continuity, is the least well understood attribute and it is therefore the focus of this discussion. In this article, we will review the evidence around relational continuity and its contribution to care outcomes. We will also discuss why it is often overlooked, the gaps in care that might result when that happens, and how it might be possible to proceed in a way that assesses the value of continuity based on a more robust, multidimensional understanding of relational continuity.

What is continuity?

Reid and colleagues[5] defined 2 core elements and 3 types of continuity. The 2 core elements of continuity include the experience of care between a patient and a provider, and care that continues over time. The 3 types of continuity are informational continuity, management continuity, and relational or interpersonal continuity.[5] *Informational* continuity is sharing "information on prior events and circumstances to make current care appropriate for the individual and his or her condition."[5] The focus is on the transfer of information about the patient and the patient's care (current and historical) between care providers and between visits to ensure clear communication of and consistency in the course of care. *Management* continuity focuses on "the provision of timely and complementary services within a shared management [or care] plan"[5] and is most vulnerable during care transitions.[6] Case management, care navigation, and clinical care guidelines are posited as strategies to enhance management continuity, and a disease-specific approach is typical. Evidence tells us that although management continuity can lead to better outcomes in the context of a particular disease, it can also lead to poorer overall outcomes for individual patients.[7]

According to Reid and colleagues, *relational* or *interpersonal* continuity refers to an ongoing therapeutic relationship between a patient and one or more providers that supports present care by linking it to the past and to the future.[5] McWhinney described longitudinality of contact as only one part of relational continuity, and explained that relational continuity was also about the trusting relationship and shared history between the patient and provider, as well as the accountabilities and mutual commitment embedded in the relationship.[8] We believe that these elements are too often overlooked when relational continuity is considered and measured. We will return to this notion later.

In terms of outcomes, the evidence suggests that longitudinality as a feature of relational continuity makes a difference, particularly for those with chronic conditions. In a systematic review of literature related to the outcomes of continuity in primary care published between 1966 and 2002, Cabana and Jee found that sustained continuity of care between a physician and a patient was associated with an improvement in quality of care, a decrease in hospitalizations and use of emergency departments, and improvement in receipt of preventive care services.[9] More recent evidence supports these findings: longitudinality has been associated with improved use of other health care resources such as specialty, laboratory, and diagnostic services; improved preventive and proactive care; more comprehensive whole-person care; and improved adherence to medical treatment.[10-17] Some have argued that the value of this continuity over time is lost on many primary care patients—namely those who just want to get in, get seen, and have their immediate (and infrequent) problems addressed in a timely manner. We would counter with the observation that this is the public expectation that has been nurtured by our medical system—we have taught the public to expect that the only purpose of primary care is to solve acute medical problems. Therefore, questioning the value of something we have taught the public not to value is a somewhat circular argument with a predictable outcome. We would argue that if a primary care relationship over time can contribute to the prevention of medical complexity, then it is worth exploring and measuring. Additionally, to argue that continuity is not as valuable as many suggest—and premise that argument on the assertion that it only makes a difference to

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those with chronic conditions—seems at odds with the observation that roughly 16 million Canadians live with 1 or more chronic diseases,[18] 80% of primary care physician visits are related to chronic disease, and more than two-thirds of all medical costs involve chronic disease.[19]

Conceptual clarity, evidence, and measurement

Despite the evidence suggesting the value of continuity of care over time, and a disease burden that has shifted considerably toward chronic conditions, we have observed little emphasis on improving relational continuity in Canada. We suggest that this might be for several interrelated reasons: a lack of conceptual clarity; measurement challenges; and an interpretation, or misinterpretation, of relational continuity that makes it seem contradictory to team-based care or at odds with good access to primary care. It must also be said that most studies on continuity and its value are cross sectional and correlational—telling us nothing about cause or about the strength of associations over time. Existing evidence also relies heavily on the measurement of longitudinality (as noted above), and the data used are typically administrative. In our own primary care organization we also measure longitudinality and have added the element of consistency (at several levels) to the metric. This allows a high-level determination of the number of times a patient seeks care from different providers in different places across our organization. We capture and measure differences in outcomes as a function of longitudinality and consistency with a single provider, with a single team, with an overall primary care practice, and across a network of practices. This metric includes instances of deflection to the emergency department for an ambulatory care sensitive condition or a family practice sensitive condition,[20,21] and enables us to associate this continuity measure with system outcomes such as hospitalization and emergency department use. Providing this metric annually over a few years has increased our understanding of how patients are using the health care system, and has allowed for the adoption of practices and processes to better meet these calls for care in primary care, resulting in diminished deflections. We have also seen improvements in guideline-concordant screening for patients who have the highest levels of continuity with their primary physicians; ie, these patients were more likely to be screened for colorectal and breast cancer and more likely to receive their pneumococcal and influenza immunizations.

Although we think this is a more robust approach to measurement, we still do not think that measuring longitudinality and consistency (or "attachment") is the whole picture in measuring relational continuity. In Greenhalgh and Heath's[22] penetrating look at the measurement of the quality of therapeutic relationships, they describe measurable structural preconditions that increase the likelihood of a therapeutic relationship forming, including the necessity of sufficient time for consultation and an ability for patients to ask for their preferred provider. Similarly, we suggest that it might well be that longitudinality and consistency are the structural preconditions that make the development of relational continuity more likely. Therefore, we view these as necessary but insufficient measures of relational continuity. Similarly, the core element of relational continuity described by Reid and colleagues[5] as "the experience of care" is most often reduced to measures of patient satisfaction.[6] It is our assertion that this retrospective, single-dimensional measure misses the co-constructed nature of the

Ways in which you can contribute to improving relational continuity in primary care

Commit to a patient population. Start with patients you are already seeing and take steps to establish mutual affiliation within an ongoing relationship focused on person-centred, comprehensive care

Understand your patient population's needs. Create registries to track chronic diseases, risk factors, and prevention or management activities. Build on what you know about the patient and tie past visit information into current activity and future plans. Get to know your patients and expect them to be accountable team members; understand their preferences and provide care in the context of family and community. View the relationship as ongoing and central to care anywhere in the system; use information systems to support this, and track and predict the demand for care that might come from your patient population and plan appropriately

Build a team around the patient population you are accountable to. The team needs to know the population and understand its changing needs over time. Team members must be visible, consistent, known to the patients, and clear about their roles and responsibilities

Be worth affiliating with. Organize how you deliver your care to be accountable, accessible, proactive, and aligned with the needs and preferences of the patient population. Commit to shared accountability for care, team development, and continuous quality improvement and measurement using proven strategies. Add measures as relevant to the population. Be proactive in managing patient needs, and search for opportunities to provide preventive care. Leverage technology to connect in ways that work for patients (eg, telephone, text, e-mail, websites) and use technology as a means to communicate or share monitoring data

Balance access and relational continuity. Team members must commit to supporting the primary patient-provider relationship and support the patient to see an appropriate member of the team in a timely manner. This means keeping handoffs between providers "warm" and as infrequent as possible

relationship between providers and patients. We suggest that the dimensions of relational continuity are not well understood and as a result we default to what we can measure: patient visits to a particular provider over time and patient satisfaction.

Team-based care, access, and relational continuity

The assumption that there is value in sustaining a relationship between a core primary care physician and a patient over time is supported by the evidence, but is often met with at least 2 subsequent questions: Is this not a throwback to "the country doctor" and therefore no longer even possible if we want to maintain good access to primary care? Is this not untenable in an era of team-based care, and even disrespectful to the contributions of others beyond the physician? It is evident that no one primary provider can be available at all times; it is not even possible for one individual to provide all the care required, especially for patients with complex chronic conditions.[23] But if one accepts that relational continuity is an important contributor to comprehensive primary care, then one might ask different questions: How, in the current context, can an ongoing relationship between a primary provider and a patient be preserved in a way that protects access to care? As to considerations around team-based care, evidence shows that the physician might not be the most appropriate provider to manage complex care. For example, it has been demonstrated that complex care management conducted by registered nurses with additional education[24] or by nurse practitioners[25] can produce superior outcomes at equivalent or reduced cost to the health system.[26] Therefore, the questions one needs to ask should be less about how continuity with a core provider might affect the team and more about how it affects the care. Do outcomes improve if relational continuity is preserved with a core provider as part of a consistent team of providers who share accountability for good overall care? How do we measure relational continuity in a way that captures the contributions of all team members, including the patient?

So where to from here?

The value of relational continuity needs to be explored in further research, and informed by better definition and measurement of all the attributes of the concept. The value of relational continuity from the patient and family's perspective is needed, especially in terms of its importance in enabling patients to reach their health goals, and particularly in the case of chronic disease. Relational continuity also needs to be explored in the context of its potential value for those who do not typically access primary care. Does a trusting mutual relationship over time assist in preventing complexity in otherwise healthy people? We would suggest that this is at least plausible, but acknowledge that, currently, this is largely an open empirical question.

Conclusion

A robust understanding of relational continuity is needed, and we believe it goes well beyond the provider-centric perspective of a reliable connection between a patient and a physician, a team, or a practice over time. It also goes beyond notions of patient satisfaction. Relational continuity, we argue, is co-constructed between patients and primary care providers (and their teams), and is about adopting a shared accountability for understanding, communicating, and meeting a patient's needs in a coordinated way—not just in primary care but across the entire system. We argue that when understood in this way, relational continuity forms the foundation for informational and management continuity. We suggest that the contribution of relational continuity is best captured by measures that give us a sense of how well the primary care provider and team are ensuring that the system wraps around the patient to provide continuous, accessible, person-centred, and comprehensive care. Without these dimensions, any measure of relational continuity is hollow.

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Competing interests
None declared

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