Strategies to enhance teaching about continuity of care

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Continuity of care is getting cookies. And not just any cookies, but homemade cookies!

Family medicine resident (K.S. and J. Kerr, unpublished data, 2009)

Continuity of care is a cornerstone of family medicine, improving physician and patient satisfaction and patient outcomes.[1-4] Focus groups with residents and practising physicians highlight that long-term relationships with patients are among their key reasons for becoming family physicians (K.S. and J. Kerr, unpublished data, 2009). Given its importance, teaching about continuity of care during residency training should be thoughtfully deliberate.

Background

Hennen[5] defined continuity of care as having 6 components: chronologic or longitudinal, informational, geographic, interdisciplinary, family, and interpersonal (**Table 1**[1,2,4-8]). These components of continuity of care have been conceptualized as relating to each other in a hierarchy with "at least some informational continuity being required for longitudinal continuity to be present and that longitudinal continuity is required for interpersonal continuity to exist."[6] Although all aspects of continuity of care are important, it is interpersonal continuity of care that is the strongest predictor of positive physician and patient outcomes.

The positive aspects of interpersonal continuity of care tend to be easily articulated. However, if we dig a little deeper, it is also obvious that continuity of care can create many difficulties: complacency, a heightened sense of responsibility with increased worry, friction between work and personal life, boundary issues, patient dependency, grief, and dealing with difficult patients.[9] Many of these factors are associated with physician stress and burnout. In teaching residents about the benefits of continuity of care, therefore, it is equally important to deliberately teach about the difficult aspects of long-term therapeutic relationships and discuss coping strategies to deal with them.

Evidence from literature and best practices

Table 1[1,2,4-8] suggests several ways to try and enhance teaching about the various components of continuity of care, ultimately working to enhance the development

Table 1. Teaching strategies for each of the 6 components of the continuity of care

COMPONENT	BENEFITS TO RESIDENT	RISKS TO RESIDENT	IMPLEMENTATION STRATEGIES
Chronologic or longitudinal[5]			
Care provided over time	Sees intervention outcomes Learns to deal with difficult situations instead of deferring		1. Have residents see the same patients in follow-ups. Try to make this process independent of the nurses or receptionists. • If using an EMR, teach residents how to book their own patients. • If the EMR is capable, link residents with their patients electronically, so anyone booking patients knows to book them with their residents. • "Assign" patients to particular columns (eg, columns 1 or 2) in the booking program. Then assign new residents to see patients in columns 1 or 2. Because patients are always assigned to the same column, residents would automatically see the same patients again. If some patients prefer male or female residents, make sure to consistently assign one column to male and one column to female residents and schedule patients appropriately. • Have appointment cards in the examining rooms; residents can fill out the cards with their names and the length of time for the next appointments. When receptionists receive these cards from the patients, they will know to book the patients with the right residents. 2. Ask receptionists not to book follow-up visits in clinics when residents are either away or on holidays. 3. Monitor and explicitly give feedback about the number of repeat visits at midrotation feedback sessions.

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COMPONENT	BENEFITS TO RESIDENT	RISKS TO RESIDENT	IMPLEMENTATION STRATEGIES
Informational[5]			
Providers have access to information about patients' previous health care encounters (ie, medical records and laboratory and x-ray results)[5,6]	Improves efficiency and safety of the encounter Increases patients' satisfaction because residents have knowledge of their histories	Records might be incomplete, particularly with respect to future management plans[7]	1. Direct laboratory work for residents' patients to the residents as well as the faculties and have residents decide the initial management plans. It is ideal to automate this as much as possible: If using an EMR and laboratory results arrive at the office electronically, have an electronic link between residents and patients, so laboratory results automatically enter residents' and faculties' electronic mailboxes. If this is not feasible, laboratory results for residents' patients would need to be manually directed to them by receptionists, nurses, or preceptors. 2. If possible and appropriate, set up general assessments early in residents' rotations to quickly increase their knowledge of patients, particularly complex patients. 3. Provide residents with patients' background information for first encounters. 4. Ask residents to write off-service notes on patients for whom continuity of care is particularly important. This has 2 benefits: Residents going off service can think about continuity issues; incoming residents are informed about the patients.
Geographic[5]			
Care provided in a variety of settings (office, home, hospital, etc)	Increases insight to understanding patient through environmental clues Enhances therapeutic relationship (eg, appreciation of patients for hospital and home visits)	Time Safety	1. Have residents provide their patients with any required housecalls or nursing home visits. As it is unlikely patients will start to need housecalls or enter nursing homes during rotations, assign residents to patients who already require such visits. 2. As opportunities for hospital visits vary, assign residents to patients who are already in hospital. If there is a discharge planning session, ask the charge nurse or social worker to involve the resident in the session, by teleconference if not in person. Ensure the resident sees that patient on discharge. 3. Have the resident follow a patient to an outpatient procedure or appointment (eg, stroke rehabilitation, cardiac rehabilitation, preoperative clinic, outpatient surgical procedure [colposcopy, colonoscopy, etc], outpatient investigation [DEXA, CT, etc], diabetes or asthma education centre, dietitian). To facilitate this type of opportunity, book residents out of clinic so they can go to these appointments, which should not be a problem because such procedures are booked in advance. Ideally, these procedures should be booked as first-of-the-day clinic appointments, minimizing residents' time away from clinics.
Interdisciplinary[5]			
Alternately defined as care provided by 1 practitioner across disciplines (eg, obstetrics, ED shifts, surgical procedures) or care coordinated as patients are followed across disciplines			1. Ensure residents either do or assist with the procedures that are within the scope of family medicine for their patients. 2. Provide residents with all consultant reports on their patients.
Family or community*			
Care provided to various family members, or care provided to various members of the same community (particularly relevant in small-town settings)	Provides additional insight about patients	Confidentiality issues Co-option into issues family members or community members have with the patient	1. Follow the booking practice listed for individual patients in the chronologic or longitudinal section (ie, book all family members in 1 column or link family members together in EMR with 1 resident), and have the resident see all family members. 2. Have residents attend patients' family counseling appointments (marital, parenting, etc).

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Table 1 *continued from page 667*

COMPONENT	BENEFITS TO RESIDENT	RISKS TO RESIDENT	IMPLEMENTATION STRATEGIES
Interpersonal[5]			
Establishment of the doctor-patient relationship	Improves job efficiency[1,2,4] Increases job satisfaction[1,2,4] Improves patient outcomes (therapeutic benefits)[4] Decreases medicolegal risk[4] Provides feedback regarding effectiveness as a physician, resulting in greater confidence[2]	Complacency (slotting patients into predetermined patterns)[2] Increases worry and anxiety about patients' health, medical management, and friction between work and personal life[2] Increases sense of conflict when duties to inform arise (driving, criminal, CAS, etc)* Causes grief when patients die or become disabled* Causes patient dependency[1,2] Creates boundary issues*	1. Deliberately place residents in situations in which either the continuity of care is very important for patients or there is increased likelihood of quickly developing a significant therapeutic relationship with patients (eg, prenatal, delivery, or postpartum, delivering bad news, palliative care, hospital visits, housecalls, chronic disease management).[2,4,8] 2. Be a role model. Discuss explicitly what you do when it comes to working on interpersonal continuity with your patients, both the positive and negative aspects, and how you cope with the negative aspects. 3. Encourage residents to care for some difficult patients; this will further enhance their understanding of the challenging aspects of continuity of care. Make sure there is time for residents to debrief with you regarding their difficult patients.

CAS—Children's Aid Society, CT—computed tomography, DEXA—dual-energy x-ray absorptiometry, ED—emergency department, EMR—electronic medical record.
*Data from K.S. and J. Kerr, unpublished data, 2009.

of interpersonal continuity of care. Different office set-ups will make some suggestions more or less workable. Thinking about the underlying intent of teaching about continuity of care (ie, facilitating the development of significant therapeutic relationships between residents and patients) will hopefully allow preceptors to modify some of the suggestions that are not immediately applicable in their settings. All suggestions presume that residents are developing cohorts of patients considered "theirs" during their rotations, and that residents must follow up on investigations and management choices for these patients.

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Competing interests
None declared

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TEACHING TIPS

- Teach residents not only the benefits of continuity of care but also the difficult aspects of long-term therapeutic relationships.
- Be a role model and discuss with residents the job satisfaction from continuity of care.
- Provide opportunities for residents to get more involved in and be responsible for patient care.

CONSEILS AUX ENSEIGNANTS

- Enseignez aux résidents non seulement les bienfaits de la continuité des soins mais aussi les aspects difficiles des relations thérapeutiques à long terme.
- Agissez comme modèle à imiter et discutez avec les résidents de la satisfaction professionnelle que procure la continuité des soins.
- Donnez la possibilité aux résidents de participer davantage et d'assumer plus de responsabilités dans les soins aux patients.

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