



### OBJECTIVE

Primary care physicians and the teams they work with will understand the value of relational continuity and therefore adopt practice behaviors that result in increased relational continuity

### TARGET POPULATION

All patients

### EXCLUSIONS

None

**IMPLEMENTATION TOOL:** Refer to the [Continuity Change Package](#)

*Note: Strongest evidence exists to support continuity to physicians. As such the focus of this guideline is physician continuity. However, the value and essential role of the primary care team to continuity, of which physicians are members, has been anecdotally and substantively demonstrated. This has therefore been acknowledged and reflected.*

### PRACTICE POINT

***Relational continuity is defined as:***

*The ongoing, trusting therapeutic relationship between a patient and a primary care physician and their team, where the patient sees this primary care physician the majority of the time and*

***results in***

*improved health outcomes, decreased mortality, better quality of care, reduced healthcare costs, increased patient and provider satisfaction, fewer ER visits and hospital admissions.*

## RECOMMENDATIONS

### RECOGNIZE THE VALUE

- ✓ Recognize the benefits and importance of relational continuity between patients and primary care physicians.
- ✓ Understand that relational continuity is the foundational building block for achieving management and informational continuity.
- ✓ Recognize that elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions may benefit most from improved continuity.
- ✓ Recognize that all patients benefit from continuity.

### PRACTICE POINT

*A patient-centered approach to primary care practice is about striving to understand each patient's values and preferences when working with them to plan and manage their care and*

**results in**

*strengthening the physician-patient relationship, changes to patient behavior to improve continuity and leveraging the patient as the leader of their own care team.*

## FOSTER PATIENT/PROVIDER (TEAM) RELATIONSHIPS

- ✓ Make an explicit agreement with the patient that the identified primary care physician will provide and/or coordinate their healthcare.
- ✓ Seek opportunities to partner with patients for shared decision making and explore their values and preferences.
- ✓ Ensure your primary care team members respect and honor shared decision making and family involvement.

## ADVISE AND ADVOCATE CONTINUITY

- ✓ Promote and advocate the value of continuity to all patients, in practice, in the community, and within the health system.
  - Advocate within health system by communicating and raising awareness of the value.
  - Educate and empower patients, families and caregivers to resolve discontinuity.

### PRACTICE POINT

*Identifying who is on your panel and making an explicit agreement with your patients is a key enabler of relational continuity and*

**results in**

*the ability to focus continuity improvement efforts based on your panel characteristics.*

## IDENTIFY AND MANAGE YOUR PANEL

- ✓ Take steps to identify your panel of unique, unduplicated patients (those with whom you have a trusting, ongoing therapeutic relationship).
  - Develop processes for panel identification and ongoing verification and maintenance.
  - Ask your patients at every opportunity, document consistently, review your list.
- ✓ Review and actively manage your panel size.

- ✓ Identify and focus on sub populations who may benefit most from continuity (e.g., elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions).
  - Develop processes to identify patient lists of clinical need.
  - Routinely review patient lists (whether patients still belong there or not).

**PRACTICE POINT**

**Office practices and processes can be designed to promote continuity**

*Working with your clinic team to improve processes for panel identification, maintenance and scheduling*

**results in**

*patients being scheduled with their own primary care physician the majority of the time and serves to enhance the ongoing relationship with their primary care physician.*

**ENABLE CONTINUITY VIA OFFICE PROCESSES**

- ✓ Aim to have your patients visit their own primary care physician >80% of the time, by adopting practice behaviors that facilitate increased continuity.
- ✓ Understand that when patients cannot see their own primary care physician that continuity can be maintained based on a hierarchy of booking for continuity and access. See [Table 1](#).

Table 1

Hierarchy of booking routine appointments
1. Book to patient’s own primary care physician (or most appropriate team member) for today.
2. Book to patient’s own primary care physician (or most appropriate team member) in the future.
3. Book for today but not with own primary care physician (or most appropriate team member).
4. Patient seeks care outside clinic (patient and provider are consciously aware of need to close the loop).

**PRACTICE POINT**

**Improved access is a key enabler of relational continuity**

*Ensuring you have the capacity to meet the needs of the patients on your panel*

**results in**

*appointments being available for patients as required with little to no wait, with patients being able to get in to see their primary care physician rather than seeking care elsewhere.*

**BALANCE DEMAND FOR CARE WITH CAPACITY (SUPPLY)**

- ✓ Improve access for appointments by exploration of the following:

- Match appointment demand to supply available.
- Optimize the care team to enhance and maximize capacity.
- Address scheduling complexities to maximize use of appointment time.
- Utilize contingency planning for both scheduled and unscheduled time away.

## MEASURE BASELINE CONTINUITY AND TRACK PROGRESS

- ✓ Understand your current rate of continuity to identify a baseline from which to improve.
- ✓ Develop, as a team, a common understanding of clinic goals that focus on the value of continuity and patient-centered care which is shared across the clinic team.
- ✓ Measure, share and display your progress toward a goal of >80% continuity at baseline and on a continuing basis.
  - Physician continuity – the number of patients’ visits to primary care physician divided by the total number of all family physician visits

### PRACTICE POINT

***Team-based care can be a key enabler for relational continuity***  
*Sharing patient care across an interdisciplinary team enables primary care physicians to provide care for more patients and*  
***results in***  
*increased patient access to their primary care physician.*

## OPTIMIZE THE PATIENT CARE TEAM TO IMPROVE AND SUPPORT CONTINUITY

- ✓ Share care for complex patients as an interdisciplinary team.
- ✓ Engage with patients as a member of their own care team.
- ✓ Create processes to support team-based care (e.g., algorithms, shared EMR, interdisciplinary huddles, regular meetings to discuss care and care coordination).
- ✓ Develop roles and responsibilities where the skill, knowledge and training of all team members is optimized.

### PRACTICE POINT

***The value of continuity applies to all settings. Context related to geography and population demographics means some areas may experience challenges to improving continuity.***

*In some areas, where demand for services exceeds primary care supply or where socioeconomic and cultural challenges exist, continuity may be impacted and*  
***results in***

*primary care physicians and team members having limited capacity to provide services and may reduce the ability to influence patient behavior to improve continuity and therefore patients seeking care elsewhere in the system.*

## OPTIMIZE ALL POTENTIAL IMPROVEMENTS IN ALL CONTEXTS

- ✓ Follow the above recommendations, particularly around access improvement to exercise all possible strategies to improve continuity
- ✓ Understand that relational continuity still holds value in all contexts and may require more innovative strategies including engagement with other groups to creatively problem solve together
- ✓ Recognize that improving continuity is a multifactorial pursuit that optimally requires effort in all areas of recommendations and despite challenges some levels of improvement can be achieved in all contexts.
- ✓ Address each recommendation based on context and capacity with the support of Alberta resources including the [Continuity Change Package](#), PCN and other provincial supports.

## IMPLEMENTATION CONSIDERATIONS

See the accompanying [Continuity Change Package](#) for advice and tools for implementing the recommendations.

## BACKGROUND

### INTRODUCTION

Continuity has been described as the degree to which a series of discrete healthcare events is experienced as coherent, connected and consistent with the patient’s medical needs and personal context.<sup>1,2</sup> It is critical to view continuity from a patient perspective. Continuity of care as described in the literature is a multidimensional concept with several inter-related components and variable and overlapping terminology.<sup>3</sup>

Relational continuity is defined as the ongoing, trusting therapeutic relationship between a patient and a primary care physician and their team, where the patient sees this primary care physician the majority of the time.<sup>2</sup>

Informational continuity is the transfer of relevant patient information between multiple care providers and locations. Includes accumulated knowledge about the patient’s preferences, values, and context.<sup>2</sup>

Management continuity is the coordination and handoff of care between relevant care providers using a shared care plan in a way that is both consistent and flexible to meet patient needs.<sup>2</sup>

Informational and management continuity optimally occur in the context of the foundation of relational continuity.

The following sections provide background information, justification, and evidence to support each of the guideline recommendations.

## RECOGNIZE THE VALUE

In order to promote and convey the importance of relational continuity with patients, primary care physicians and their teams need to understand and recognize the benefits themselves. Here we summarize the strong evidence base for relational continuity in primary care.

Continuity has been shown to improve health outcomes, decrease mortality, lead to better quality of care, reduce healthcare costs, increase patient and provider satisfaction, and lead to fewer ER visits and hospital admissions.<sup>1,4-17</sup>

For some measures, (e.g., utilization, mortality) the greater the degree of continuity, the better the outcomes.<sup>15,18-29</sup>

Relational continuity has been studied extensively in patients with complex needs and has displayed consistently improved outcomes in these groups,<sup>13,22-25,30-36</sup> and in some cases there was a greater impact in these groups when compared to those without complex needs.<sup>37,38</sup> Thus, it can be said that elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions may benefit most from improved continuity. No evidence exists that demonstrates harm in any population.

Relational continuity is valued by patients, particularly those with complex needs or a chronic disease.<sup>6,14,39-45</sup>

Relational continuity is valued by providers, especially when treating patients with complex needs.<sup>14,39,41,46-48</sup>

The impact of continuity has been studied in Alberta by the Health Quality Council of Alberta (HQCA),<sup>1,14</sup> the Canadian Institute for Healthcare Improvement (CIHI),<sup>9</sup> and Alberta Health.<sup>49</sup> Their findings echo those in the general literature discussed above, finding multiple significant benefits of relational continuity for Albertans.

Strongest evidence exists to support continuity to physicians. As such the focus of this guideline is physician continuity. However, the value and essential role of the primary care team to continuity, of which physicians are members, has been anecdotally and substantively demonstrated. Team-based care is also recognized as a key pillar of the patient’s medical home.<sup>50</sup> This has therefore been acknowledged and reflected.

Continuity is a key implementation element and building block for the patient's medical home (PMH),<sup>50,51</sup> and is a key component of high performing primary health care.<sup>51,52</sup> The patient's medical home has been associated with fewer emergency visits and hospitalizations, cost savings, improved quality, improved access, and improved patient and provider satisfaction.<sup>53</sup>

## FOSTER PATIENT/PROVIDER (TEAM) RELATIONSHIPS

Relational continuity at its heart is about a longitudinal trusting relationship between patient and provider. A patient-centered approach to primary care practice is about striving to understand each patient's values and preferences when working with them to plan and manage their care and results in strengthening the physician-patient relationship, changes to patient behavior to improve continuity and leveraging the patient as the leader of their own care team.

A patient centered approach to primary care has been linked with improved patient satisfaction and activation and with perceived quality of care.<sup>54-56</sup>

One study found that patients felt that continuity of care was best realised when they could consult a doctor who had been specifically appointed to them.<sup>57</sup> Moreover, as demonstrated above, patients value relationship continuity with their primary care physician.

## ADVISE AND ADVOCATE CONTINUITY

At each interaction, physicians and team members have the opportunity to reinforce the value of continuity with their patients. Educating and empowering patients, families and formal or informal caregivers to resolve discontinuity can aid in improving continuity.

Practitioners and patients also have a role in advocating for continuity within the health system. When interacting in the larger system both providers and patients, should capitalize on opportunities to advocate for care that allows for the transfer or relevant information between multiple care providers and locations, with good coordination and handoffs of care in a way that is consistent and flexible to meet patient needs, preferences and values. The longitudinal, trusting relationship between the patient and their primary care physician and team must be central to all coordination and information sharing.

## IDENTIFY AND MANAGE YOUR PANEL

Identifying who is on your panel by making an explicit agreement with your patients to develop a relationship through which primary care services are provided, is a key enabler of relational continuity and results in the ability to focus continuity improvement efforts based on your panel characteristics.

Panel management is a fundamental element of high-performing primary care. It has been associated with improved quality and care process outcomes.<sup>51,58-60</sup>

It is important to review and actively manage your panel size. Panel size can impact access to one's own primary care physician and therefore relational continuity.<sup>61-63</sup>

Practitioners can also use their panel to identify populations who might particularly benefit from continuity. As stated above, elderly patients, vulnerable populations, and those with complex needs or multiple chronic conditions may benefit most from relational continuity.

## ENABLE CONTINUITY VIA OFFICE PROCESSES

Working with your clinic team to improve processes for panel identification, maintenance and scheduling results in patients being scheduled with their own primary care physician the majority of the time and serves to enhance the ongoing relationship with their primary care physician.

This guideline recommends that you should aim to have your patients visit their own primary physician >80% of the time. While there is not currently a clearly identified target for relational continuity across the research literature, Alberta data suggests 80% as a desired target. In a study conducted by the HQCA using Alberta administrative data, it was found that patients who saw the same primary care physician for 80% or greater of their primary care visits used significantly less healthcare acute care services overall. This effect remains after adjusting for age and gender, is seen across all burden of illness categories, and was present before and after PCNs were formed. This effect was not seen for patients who saw the same physician for 50% or fewer of their primary care visits.<sup>1</sup>

It is recognized that it may not always be possible for patients to see their own primary care physician on the day they request despite best efforts to maintain good access. Mitigating discontinuity is a key objective of a primary care system. Some degree of continuity can be maintained based on a hierarchy of booking. See [Table 1](#) for our recommended hierarchy. Through teamwork and coordination, appointments can be scheduled in such a way as to promote care delivery by those who have some degree of relationship with the patient within the patient's medical home. Consequently, it is not only important to maximize continuity but to manage the inevitable discontinuity via clear booking practices and other office processes.<sup>3</sup>

## BALANCE DEMAND FOR CARE WITH CAPACITY (SUPPLY)

Improved access is a key enabler of relational continuity. Ensuring you have the capacity to meet the needs of the patients on your panel results in appointments being available for patients as required with little to no wait, with patients being able to get in to see their primary care physician or team rather than seeking care elsewhere.

Poor access that results in high wait times has been found to result in lower future reliance on one's primary care physician,<sup>64</sup> and decreased patient satisfaction.<sup>65</sup> This has an impact on the patient's desire and ability to maintain the relationship with their primary care provider and can result in decreased continuity.

There are many ways the primary care physician and their team can improve access. At a basic level, if demand for services exceeds the supply or clinical capacity this will result in poor access. The first step toward improving access is identification of the number of unique, unduplicated patients on your panel. This number when multiplied by the average return visit rate (available via HQCA reporting) will provide you with the total demand for services. Efforts to match this number with the number of appointments you have available in your schedule will aide in improving access and

thereby continuity. Please refer to the [Continuity Change Package](#) for further information and strategies for how to achieve balance between demand for care with capacity.

## MEASURE BASELINE CONTINUITY AND TRACK PROGRESS

Understanding your current rate of continuity is important in order to achieve a baseline from which to improve. Some measures of continuity can be tracked using HQCA panel reports:

- Physician continuity - the number of patients' visits to primary care physician divided by the total number of all family physician visits.
- Average physician continuity - the sum of all individual patients' physician continuity divided by the total number of patients in the physician panel.
- Facility continuity - the number of family physician visits to a primary care facility divided by the total number of all facility visits.
- General practitioner sensitive condition visits - the average number of general practitioner sensitive condition visits to the ED by a patient panel.

Develop, as a team, a common understanding of clinic goals that focus on the value of continuity and patient-centered care which is shared across the clinic team.

Tracking these measures regularly will allow for understanding of whether efforts to improve continuity are resulting in positive effect toward your clinic goal.

Measure, share and display your progress toward 80% continuity at baseline and then on a continuing basis.<sup>66</sup>

Although physician leadership is critical to success, empowering and leveraging the creative ideas of the team will distribute the workload and responsibility for improvement activities so no one person carries the entire load.

## OPTIMIZE THE PATIENT CARE TEAM TO IMPROVE AND SUPPORT CONTINUITY

Team-based care can be a key enabler for relational continuity. Sharing patient care across an interdisciplinary team enables primary care physicians to provide care for more patients and results in increased patient access to their primary care physician.

Matching patient needs with the skills, knowledge and expertise that interdisciplinary team members bring enhances the quality of care provided. In the context of each patient having a personal family physician and where each care provider is recognized as a member of the patient's personal medical home team, all members are encouraged to develop ongoing relationships with patients.<sup>50,67</sup>

Team-based primary health care has been associated with improved quality and outcomes of care and enables successful implementation of primary care innovations such as the patients' medical home.<sup>51,68-73</sup>

## OPTIMIZE ALL POTENTIAL IMPROVEMENTS IN ALL CONTEXTS

The value of continuity applies, and efforts should be made to improve in all settings. Context related to geography and population demographics means some areas may experience challenges to improvement efforts. In some areas, where demand for services exceeds primary care supply or where socioeconomic and cultural challenges exist, continuity may be impacted and results in primary care physicians and team members having limited capacity to provide services and ability to influence patient behavior to improve continuity and therefore patients seeking care elsewhere in the system.

Follow the above recommendations, particularly around access improvement to understand what is achievable within your context. Understand that improving continuity is a multifactorial pursuit that optimally requires effort in all areas of recommendations and positive gains can be made despite contextual issues. Address each recommendation based on context and capacity with the support of Alberta resources including the [Continuity Change Package](#), PCN and other provincial supports.

As cultural norms and expectations shift over time both with providers and patients and as efforts and practices to improve and maintain continuity become socialized across the system this can only serve to elevate the ability to positively impact results in all geographical areas and populations, resulting in better outcomes for all patients.

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### ***GUIDELINE WORKING GROUP***

See [Authorship and Disclosed Conflict of Interest Summary](#) for information on the guideline working group members.

### ***DATES***

June 2019

## AUTHORSHIP AND DECLARATION OF CONFLICT OF INTEREST

Relational Continuity Committee Members and Disclosed Conflicts of Interest Summary											
*on topics related to the CPG **from a commercial organization											
Name, credentials	Affiliation	Written articles*	Presented*	Created apps, software, tools, etc.*	On Advisory Board**	On Speakers' bureau**	Received Payment**	Grant(s) or Honorarium**	Patent	Investments	Clinical trial
Amy Tan, MD MSc, CCFP(PC) FCFP	Associate Prof, Dept of Family Medicine U of C	No	Leading study to improve primary palliative care access to patients in Calgary Zones	No	No	No	No	No	No	No	No
Deborah Ferguson, MD FCFP	U of C Clinical Assistant Professor	No	No	No	No	No	No	No	No	No	No
Papanna Praveen M.B.B.S., C.C.F.P.	CFPC CPSA	No	No	No	No	No	No	No	No	No	No
Lee Green MD MPH	U of A Professor and Chair Family Medicine University of Alberta AIHS Translational Health Chair	Yes Authored multiple articles in the academic literature on the Medical Home model	Yes Presented at national and international meetings on Medical Home model research	No	No	No	No	No	No	No	No

These recommendations are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. They should be used as an adjunct to sound clinical decision making.

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*on topics related to the CPG **from a commercial organization											
Name, credentials	Affiliation	Written articles*	Presented*	Created apps, software, tools, etc.*	On Advisory Board**	On Speakers' bureau**	Received Payment**	Grant(s) or Honorarium**	Patent	Investments	Clinical trial
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Ernst Greyvenstein MBChB, CCFP, FCFP, Dip. PEC	PCN Physician Leads Executive Calgary Zone South Calgary PCN Board Chair SAPCA Director Clinical Associate Professor University of Calgary Medical Director Circle Medical Ltd.	No	No	No	No	No	No	No	No	No	No
June Bergman MD, CCFP, FCFP Assoc Prof Emerita	U of C	No	No	No	No	No	No	No	No	No	No

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Ravi Patel MD CCFP	U of C Depart of Family Medicine	No	No	No	No	No	No	No	No	No	No
Richard Lewanczuk	AHS Medical Director Enhancing Care in the Community	No	No	No	No	No	No	MERCK Presented CME – approved by ACFP	No	No	No
Rick Neuls	Allin Clinic AIM, Edmonton PCA	No	Quality improvement literature as AIM faculty through AHS	No	AIM Faculty		AIM Faculty	No	No	No	No

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