EHMA 2025

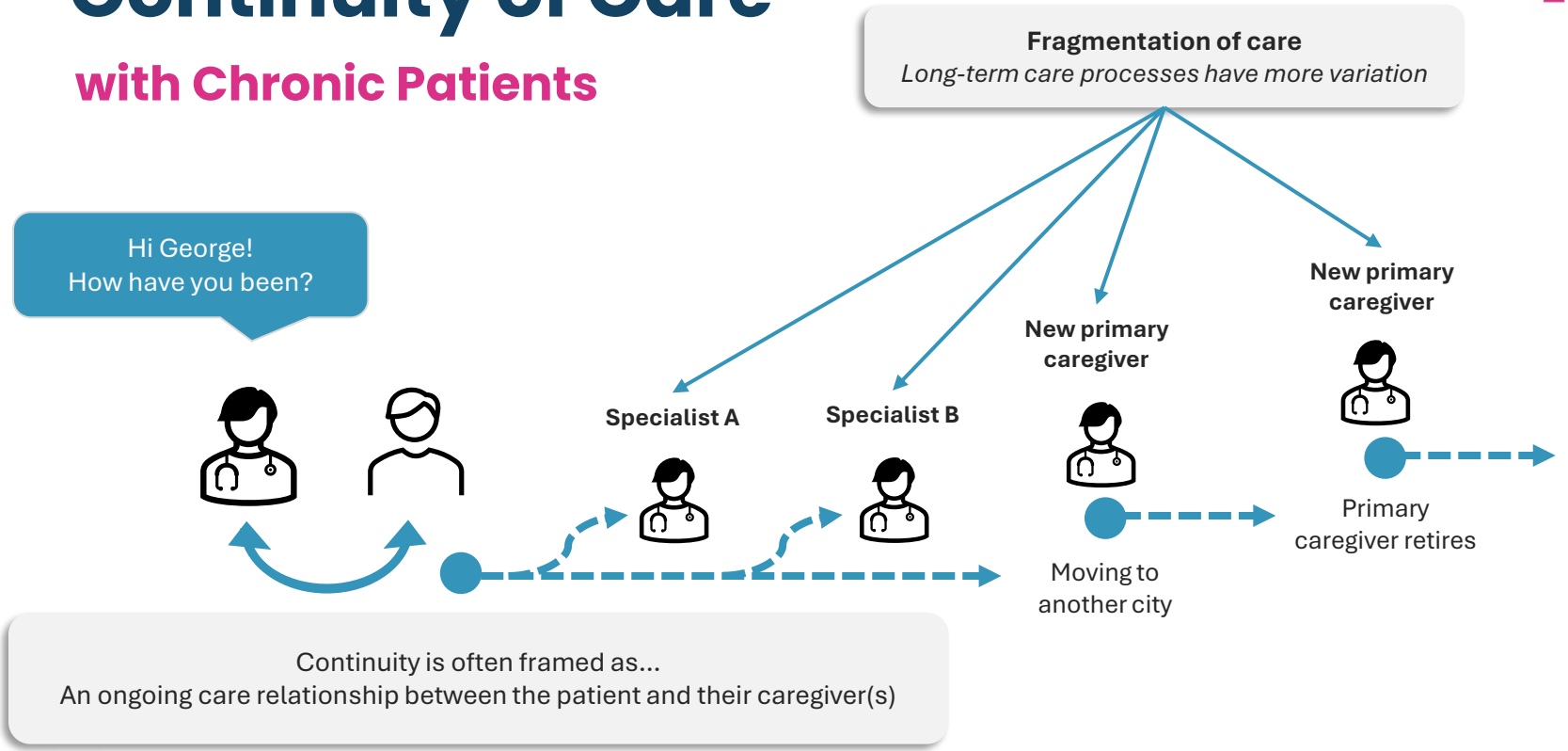
Taking action to improve health for all

Continuity of Care

How to go forward?

Continuity of Care

with Chronic Patients



Continuity is often framed as...
An ongoing care relationship between the patient and their caregiver(s)

1 The 3 Dimensions of Continuity (Haggerty et al., 2003)

Relational continuity – ongoing relationships

Informational continuity – using patient data to personalise care

Management continuity – consistent and adapts to changing needs

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.

3 Considerations on Continuity Measures

Missed Care Ignored
Only counts visits, not care that was delayed or never provided.

Outcomes Not Reflected
High scores don't ensure better, timely, or effective care.

Narrow Focus
Measures only provider consistency, not overall care coordination.

2 Operationalization of Continuity Has Focused on Relational Continuity

Measure	Focus
COCI (Continuity of Care Index)	Evenness across all providers
UPC (Usual Provider of Care)	Proportion with top provider
SECON (Sequential Continuity of Care Index)	Sequential same-provider visits
HI (Herfindahl Index)	Concentration of visits among different providers

Pollack, C. E., Hussey, P. S., Rudin, R. S., Fox, D. S., Lai, J., & Schneider, E. C. (2016). Measuring Care Continuity. Medical Care, 54(5), e30–e34.

4 Research Gap

RQ: *What factors contribute to the continuity of care in chronic disease management?*

Research methods and data

DATASET 1

- Private Nordic healthcare company
- Focus group (N = 7)
- Semi-structured interviews (N = 9)

DATASET 2

- Public healthcare professionals working with older patients
- Focus group (N = 9)

ANALYSES

- Inductive thematic analyses
- Inspired by Gioia et al. (2013)

Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology. Organizational Research Methods, 16(1), 15–31.

Findings

Data Structure

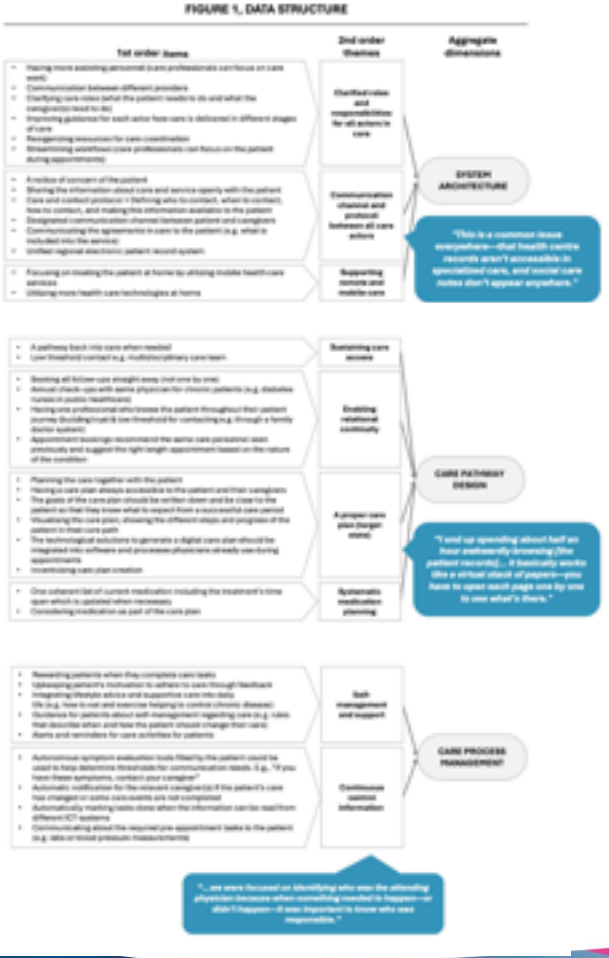
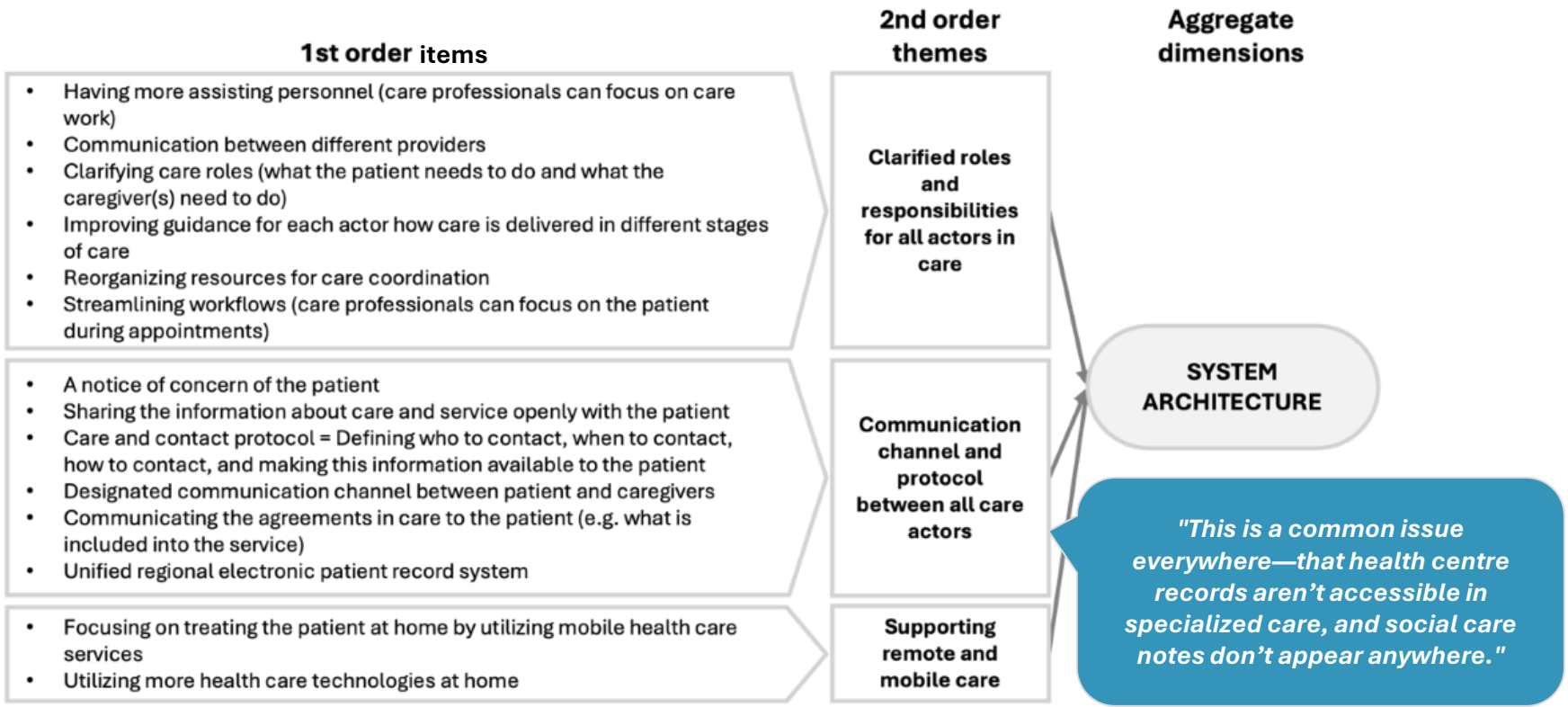
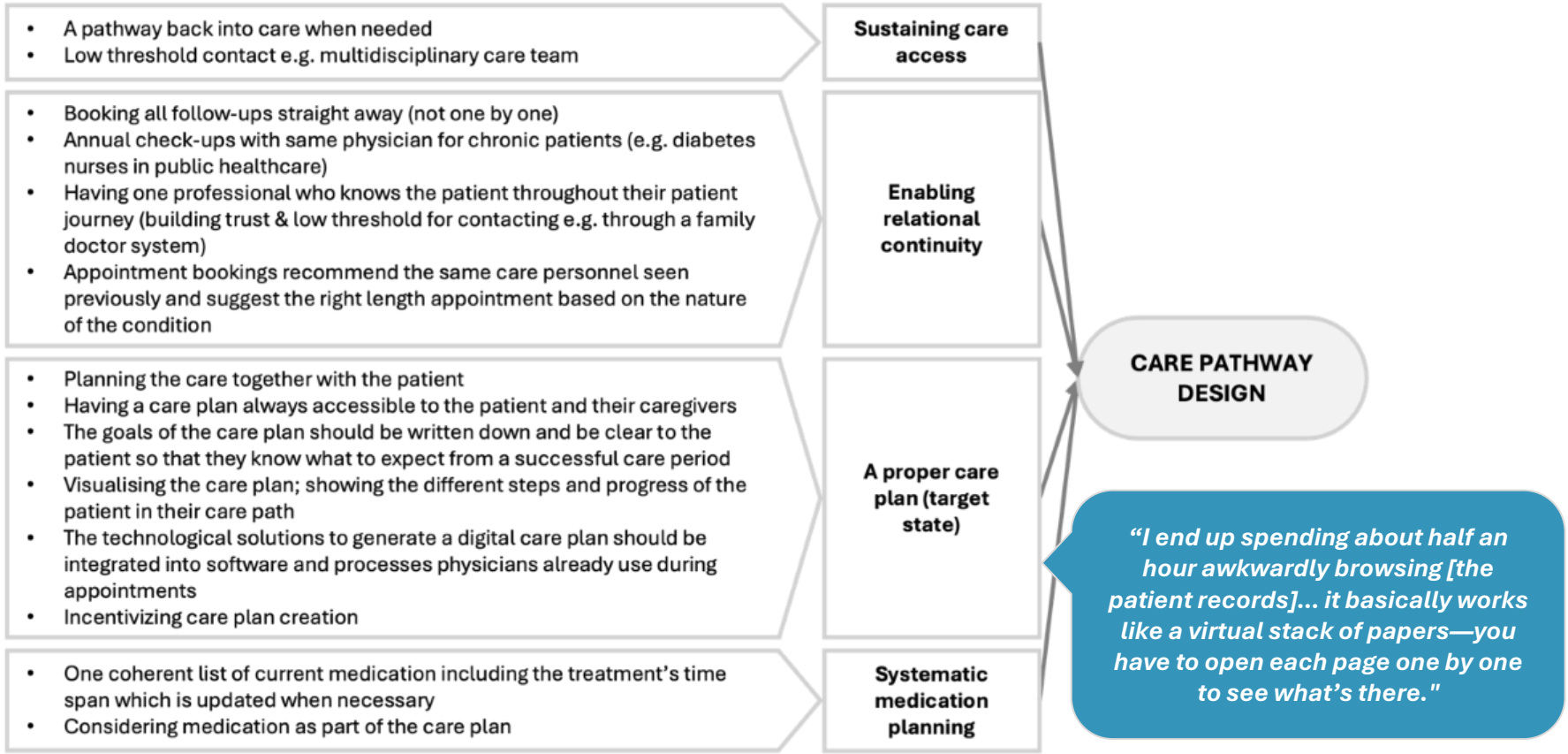
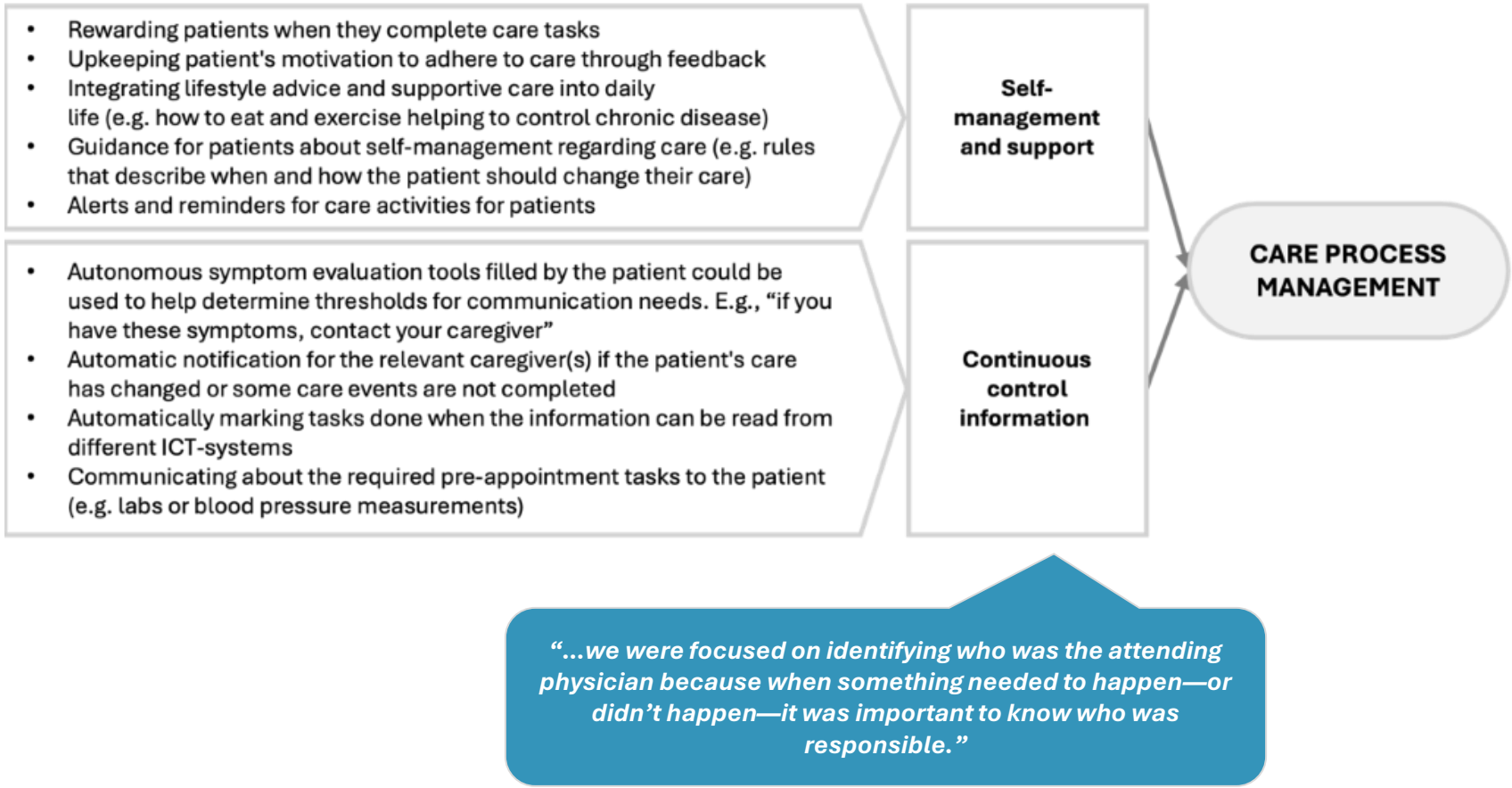


FIGURE 1, DATA STRUCTURE

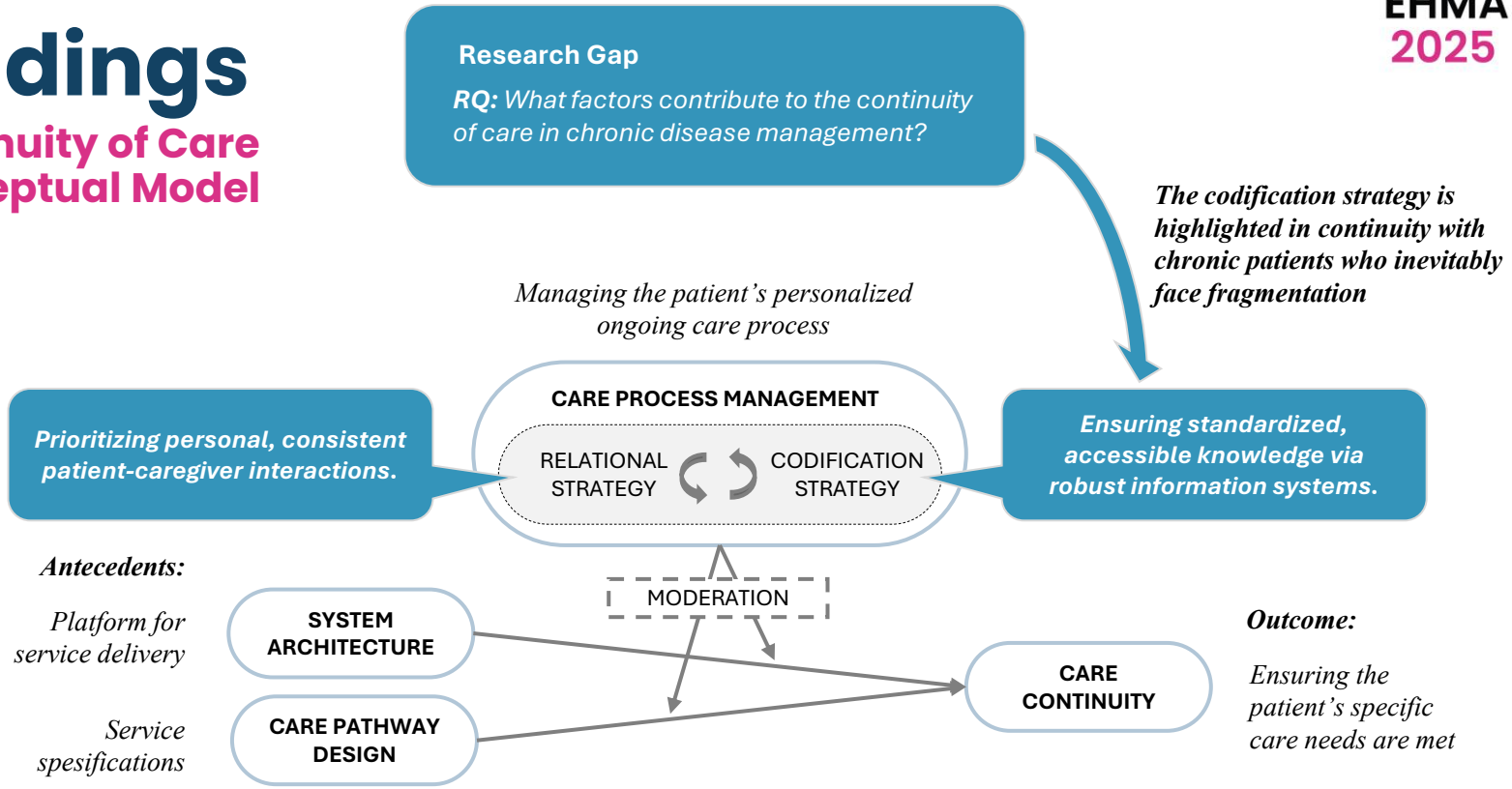



A pathway back into care when needed
Low threshold contact e.g. multidisciplinary care team
Sustaining care access
Booking all follow-ups straight away (not one by one)
Annual check-ups with same physician for chronic patients (e.g. diabetes nurses in public healthcare)
Having one professional who knows the patient throughout their patient journey (building trust & low threshold for contacting e.g. through a family doctor system)
Appointment bookings recommend the same care personnel seen previously and suggest the right length appointment based on the nature of the condition
Enabling relational continuity
Planning the care together with the patient
Having a care plan always accessible to the patient and their caregivers
The goals of the care plan should be written down and be clear to the patient so that they know what to expect from a successful care period
Visualising the care plan; showing the different steps and progress of the patient in their care path
The technological solutions to generate a digital care plan should be integrated into software and processes physicians already use during appointments
Incentivizing care plan creation
A proper care plan (target state)
One coherent list of current medication including the treatment's time span which is updated when necessary
Considering medication as part of the care plan
Systematic medication planning
CARE PATHWAY DESIGN
"I end up spending about half an hour awkwardly browsing [the patient records]... it basically works like a virtual stack of papers—you have to open each page one by one to see what's there."


Rewarding patients when they complete care tasks
Upkeeping patient's motivation to adhere to care through feedback
Integrating lifestyle advice and supportive care into daily life (e.g. how to eat and exercise helping to control chronic disease)
Guidance for patients about self-management regarding care (e.g. rules that describe when and how the patient should change their care)
Alerts and reminders for care activities for patients
Self-management and support
Autonomous symptom evaluation tools filled by the patient could be used to help determine thresholds for communication needs. E.g., "if you have these symptoms, contact your caregiver"
Automatic notification for the relevant caregiver(s) if the patient's care has changed or some care events are not completed
Automatically marking tasks done when the information can be read from different ICT-systems
Communicating about the required pre-appointment tasks to the patient (e.g. labs or blood pressure measurements)
Continuous control information
CARE PROCESS MANAGEMENT
"...we were focused on identifying who was the attending physician because when something needed to happen—or didn't happen—it was important to know who was responsible."

Findings

Continuity of Care Conceptual Model



Operationalization of the constructs

Implications for future

1. **Validate the Conceptual Continuity Model**

   Test the model's relevance across varied healthcare systems beyond Finland.

2. **Measures for the Codification Strategy**

   Develop metrics for standardized processes and information flow to complement the relational strategy measures.

3. **Uncover Continuity Mechanisms**

   Investigate how the identified system design features produce continuity.

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THANK YOU

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