

# Measure #68. Patient Perceived Continuity of Care from Multiple Providers

**CARE COORDINATION MEASURE MAPPING TABLE**

	MEASUREMENT PERSPECTIVE		
	<i>Patient/Family</i>	<i>Health Care Professional(s)</i>	<i>System Representative(s)</i>
<b>CARE COORDINATION ACTIVITIES</b>			
Establish accountability or negotiate responsibility	■		
Communicate	■		
<i>Interpersonal communication</i>	■		
<i>Information transfer</i>	■		
Facilitate transitions			
<i>Across settings</i>	■		
<i>As coordination needs change</i>	□		
Assess needs and goals	■		
Create a proactive plan of care	■		
Monitor, follow up, and respond to change	□		
Support self-management goals	■		
Link to community resources			
Align resources with patient and population needs			
<b>BROAD APPROACHES POTENTIALLY RELATED TO CARE COORDINATION</b>			
Teamwork focused on coordination	■		
Health care home			
Care management			
Medication management			
Health IT-enabled coordination			

**Legend:**

- = ≥ 3 corresponding measure items
- = 1-2 corresponding measure items

# Patient Perceived Continuity of Care from Multiple Providers

**Purpose:** To measure management continuity from the perspective of patients with health problems who regularly see more than one clinician.

**Format/Data Source:** A 53-item, paper-based survey asking patients to report their experiences with continuity of care. Questions focus on assessing the roles of the clinicians as care coordinators, with a total of 8 constructs across 9 subscales. Three subscales relate to the principal clinician and cover management and relational continuity (coordinator role, comprehensive knowledge of patient, confidence and partnership). Four subscales are related to multiple clinicians and address team relational continuity and problems with coordination and gaps in information transfer (confidence in team, role clarity and coordination [2 subscales], information gap between clinicians). Two subscales pertain to the patient's partnership in care (evidence of a care plan, self-management information provided). Response choices are on a 5-point Likert-type scale for most questions, with a 3-point scale for some.<sup>1</sup>

**Date:** Measure released in 2012.<sup>1</sup>

**Perspective:** Patient/Family

## Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** 11, 17, 19, 37, 38, 39, 41f, 41g, 41k
- **Communicate:**
  - *Between health care professional(s) and patient/family:* 3, 4, 5
  - *Within teams of health care professionals:* 9, 17, 41h, 41k
  - *Across health care teams or settings:* 13, 17, 41h, 41k
  - Interpersonal communication:
    - *Between health care professional(s) and patient/family:* 16, 20, 21, 22, 23, 24, 25
    - *Across health care teams or settings:* 15
  - Information transfer:
    - *Between health care professional(s) and patient/family:* 32, 33, 34, 35
    - *Across health care teams or settings:* 27, 28, 29, 31, 41e
- **Facilitate transitions:**
  - Across settings: 14, 16, 17, 19, 23, 27, 28, 29, 31, 41k
  - As coordination needs change: 41i
- **Assess needs and goals:** 3, 4, 5, 12, 24, 37
- **Create a proactive plan of care:** 19, 20, 21, 22, 23, 24, 41i
- **Monitor, follow up, and respond to change:** 11, 41j
- **Support self-management goals:** 21, 25, 32, 33, 34, 35, 41i
- **Teamwork focused on coordination:** 9, 18, 19, 36

**Development and Testing:** Measure items were developed based on themes from 23 existing instruments measuring patient experience with care from various clinicians. The measure was validated with patients ages 25 to 75 years old. Item-scale correlations generally indicated high

consistency within the subscales, with an internal reliability that was higher than the generally accepted score of 0.70; the role clarity and coordination within the clinic subscale had a borderline reliability score of 0.66. This somewhat lower value reflected the small number of respondents consulting various clinicians in their regular clinic in the last 6 months. Factor analysis showed that all items loaded within the expected patterns. Odds ratios of occurrence of indicators of problem continuity demonstrated that all but one of the subscale constructs were protective against discontinuity of care (OR 0.16 to 0.67). One of the subscales indicated an increased risk of discontinuity, inappropriate ED use, and medical errors (OR 2.67 to 18.05).<sup>1</sup>

**Link to Outcomes or Health System Characteristics:** None described in the sources identified.

**Logic Model/Conceptual Framework:** None described in the source identified.

**Country:** United States

**Past or Validated Applications\*:**

- **Patient Age:** Adults
- **Patient Condition:** Not Condition Specific
- **Setting:** Primary Care Facility, Other Outpatient Specialty Care Facility

\*Based on the source listed below and input from the measure developer.

**Notes:**

- All instrument items are located in an online supplementary appendix associated with the main source article.<sup>1</sup>
- This instrument contains 53 items, of which 39 were mapped.
- A French version of the survey is also available.<sup>1</sup>

**Sources:**

1. Haggerty JL, Roberge D, Freeman GK, et al. Validation of a generic measure of continuity of care: when patients encounter several clinicians. *Ann Fam Med* 2012;10(5):443-51.