

## Measure #69. Relational and Management Continuity Survey in Patients with Multiple Long-Term Conditions

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

# Relational and Management Continuity Survey in Patients with Multiple Long-Term Conditions

**Purpose:** To quantify problems of relational and management continuity in patients with multiple long-term conditions.

**Format/Data Source:** A 25-item self-administered survey. Item responses use a 4-point Likert-type scale indicating frequency of experiencing varies kinds of management and relational continuity. The survey contains 4 sections: (1) utilization of services, (2) management continuity, (3) relational continuity, and (4) access, flexibility, and satisfaction. Scores calculated for each of two factors (management continuity, relational continuity) indicate the number of difficulties experienced by patients for that type of continuity.<sup>1</sup>

**Date:** Measure released in 2011.<sup>1</sup>

**Perspective:** Patient/Family

## Measure Item Mapping:

- **Establish accountability or negotiate responsibility:** 30, 31, 36
  - Interpersonal communication:
    - *Between health care professional(s) and patient/family:* 11
    - *Within teams of health care professionals:* 30
  - Information transfer:
    - *Across health care teams or settings:* 25, 26, 27, 28, 29
- **Assess needs and goals:** 11, 13
- **Create a proactive plan of care:** 31
- **Monitor, follow up, and respond to change:** 7
- **Teamwork focused on coordination:** 30, 37

**Development and Testing:** Psychometric testing in a sample of 1,125 patients age 60 and older from 15 general practices in the U.K. demonstrated good reliability and validity. Confirmatory factor analysis revealed that survey items cluster into two factors: management continuity (7 items, Cronbach's alpha 0.884) and relational continuity (9 items, Cronbach's alpha 0.830). Other items showed poor results and were omitted from analyses. Patients with a greater number of self-reported chronic conditions were more likely to experience three or more difficulties in management continuity ( $p < 0.05$ ) compared to those with fewer chronic conditions, controlling for age, sex, clinic, and health care utilization. In contrast, difficulties in relational continuity were not associated with chronic disease burden. Patients with greater numbers of general practice visits experienced fewer relational continuity difficulties.<sup>1</sup>

**Link to Outcomes or Health System Characteristics:** Hospital outpatient consultations (specialty visits) and emergency department visits were strongly associated with greater difficulties in management continuity but not relational continuity among older adults in U.K. general practices, when controlling for age, sex, clinic, and number of chronic conditions. Patients with poorer self-rated health also reported experiencing greater difficulties in both

management and relational continuity in adjusted analyses. Practice size and number of physicians in a practice were not associated with either management or relational continuity. Difficulties in management continuity were greater at clinics where patients experienced lower relational continuity ( $p < 0.02$ ).<sup>1</sup>

**Logic Model/Conceptual Framework:** This measure emerges from conceptual work on differing aspects of continuity of care.<sup>1,2</sup>

**Country:** UK

**Past or Validated Applications\*:**

- **Patient Age:** Adults, Older Adults
- **Patient Condition:** Combined Chronic Conditions, General Chronic Conditions, Multiple Chronic Conditions
- **Setting:** Primary Care Facilities

\*Based on the sources listed below and input from the measure developers.

**Notes:**

- All instrument items are located in Table 2 of the source article.<sup>1</sup>
- This instrument contains 25 items, of which 12 were mapped.

**Sources:**

1. Gulliford M, Cowie L, Morgan M. Relational and Management Continuity Survey in Patients with Multiple Long-Term Conditions. *Journal of Health Services & Research Policy* 2011;16(2):67-74.
2. Gulliford M, Naithani S, Morgan M. What is 'continuity of care'? *Journal of Health Services & Research Policy* 2006;11(4):248-50.