



# IMPROVEMENT STRATEGIES MODEL: HIGH QUALITY PRIMARY HEALTH CARE: CONTINUITY

Led by: **BILL & MELINDA**  
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## CORE PRINCIPLES OF PRIMARY HEALTH CARE

High-quality primary health care systems consistently deliver services that are trusted and valued by the people they serve and improve health outcomes for all. (1-4) High-quality primary health care is the outcome of strong service delivery and the result of well organized and managed services, backed by a strong system and adequate inputs, such as human resources, infrastructure, and drugs and supplies. This module focuses on what systems, policies, and infrastructure should be in place to ensure the delivery of high-quality primary health care services. Within the PHCPI framework, five core functions underpin high-quality care delivery in primary health care systems. These include first contact accessibility, coordination, continuity, comprehensiveness, and person-centeredness. (2,5) Improving the delivery of these functions is central to obtaining the benefits of person-centered primary care systems. (2,4,6)

High-quality care is often least accessible to the most vulnerable groups, and therefore ensuring the delivery of high-quality primary health care involves taking into account the wide array of individual and/or community socioeconomic characteristics—including poverty, gender, sex or sexual identity, caste, ethnicity, age, and race. (4) These social determinants may have a significant impact on the delivery of care within or between countries, and improvement may require concomitant efforts to improve social disparities.

### FIRST CONTACT ACCESSIBILITY

High-quality primary health care can meet 90% of population health needs (1,2) and should be the first point of contact or entry-point to the health system for most health needs, most of the time. To be an effective first point of contact, primary health care must consistently delivery services that users trust, value, and can easily access.

### CONTINUITY

Continuity refers to a long-term healing relationship between a person and his or her primary care provider or care team over time. Continuity creates an environment in which patients experience discrete health care events as coherent, connected, and consistent with their medical needs and personal context throughout their life course. There are at least three types of continuity considered to be important for primary care (7): Relational continuity - An ongoing therapeutic relationship between a patient and one or more providers; Informational continuity - The use of information on past events and personal circumstances to make current care appropriate for each individual; and Management continuity - The extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent. It can also be thought of as a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.

### COMPREHENSIVENESS

Comprehensiveness refers to the provision of holistic and appropriate care across a broad spectrum of health problems, age ranges, and treatment modalities. (2,8,9) High-quality primary health care treats the 'whole' person within their family, cultural, and community context - delivering a wide range of preventive, promotive, disease-management, and rehabilitative services. (10,11) To address an individual's full range of needs - taking into account the political, economic, social, and environmental determinants of health - a wide scope of services must be available and integrated across levels of care and between the health and non-health sectors.

## **COORDINATION**

Coordinated care is an integrating function that includes appropriate management of care between providers and across levels of care and time. (2,10,12) High-quality primary health care is coordinated around a person's needs and preferences throughout treatment and across various care sites. Coordination ensures appropriate follow-up treatment, minimizes the risk of error, and prevents complications. Coordination of care often requires proactive outreach on the part of health care teams as well as systems for informational continuity.

## **PERSON-CENTEREDNESS**

Person-centered care is organized around the comprehensive needs of people rather than individual diseases. It engages and empowers people in full partnership with health care providers in promoting and maintaining their health. Person-centered care considers a patient's social, career, cultural, and family priorities as important facets of health. Understanding system performance from the perspective of the user of the system is critical to assessing overall function as well as improvement initiatives.

## **HIGH QUALITY PRIMARY HEALTH CARE: WHAT ARE THE KEY PRINCIPLES?**

The following principles should be prioritized simultaneously to improve the design of health systems that promote high-quality primary health care.

### **PERSON-CENTEREDNESS**

While there are many supply-side considerations for first contact access at the system and organizational-level, services that are acceptable (trusted and of-value) from the patient perspective will make it more likely that patients will seek services. Person-centeredness is an important function for improving the capacity of PHC systems to deliver services that are trusted and valued by patients. Person-centered health-systems engage people as equal partners in promoting and maintaining their health in a way that integrates the existing cultural context such as attitudes, beliefs, and concerns. However, in order to be empowered users of the health system, patients must have the ability to make informed decisions and participate in their own care. While there are a varying degrees of improvements to be made to achieve person-centered health systems to the fullest extent, a minimum level of acceptability (trust and value placed in the system) must be in place for primary health care to be utilized as the first point of contact.

### **PRIMARY HEALTH CARE AS THE FIRST POINT OF CONTACT**

The capacity of PHC to effectively serve as the first point of contact hinges on the consistent delivery of high-quality comprehensive care that is trusted and valued by users. However, comprehensive care will not in itself translate to better health outcomes if it is not utilized as first contact care. In order for patients to receive high-quality primary health care, primary care facilities must be both accessible, (facilities are physically present and accessible to populations in terms of geographic proximity, cost, and convenient hours of operation and waiting times) and acceptable (trusted and valued by users). From the system level, this is influenced by the creation and enforcement of national standards and guidelines (across private and public sectors), the skill and motivation of the primary health care workforce, and the availability of inputs, infrastructure, and information systems. From the patient-perspective, utilization is influenced by contextual factors at the individual and local level, including social and cultural norms and beliefs and decision-making capacity. With these foundational elements in place, service delivery activities, such as empanelment and proactive population outreach, help to facilitate primary care as the first point of contact and enable coordination across the continuum of care.

## INTEGRATED CARE DELIVERY SYSTEMS

To best meet the complex needs and preferences of populations, primary health care services should be comprehensive. Integrated health service delivery is an approach to strengthening person-centered health systems through the delivery of comprehensive services, coordinated around the needs and preferences of a person throughout their life course and care settings. (13,14) Integrated models that offer a more comprehensive set of skills and services at the frontline (including diagnostic, pharmaceutical, behavioral, and rehabilitative services) can help to increase the efficiency and timeliness of primary health care, increasing the capacity of primary care to serve as the first point of contact (15-17) Integrated models are strengthened by the use of referral networks and interoperable information systems that promote bi-directional communication channels.(18-20)

## TOOLS & FRAMEWORKS

This subdomain focuses on the delivery of high-quality primary health care from the perspective of both the user and the system. High-quality primary health care is an outcome within Service Delivery - these functions of PHC are often a result of various elements within System, Inputs, and other components of Service Delivery. The framework below calls for a fundamental shift in the way health services are funded, managed, and delivered to promote universal access to high-quality person-centered care. The framework is adaptable to all countries and health systems.

## WHO FRAMEWORK ON INTEGRATED PEOPLE-CENTERED HEALTH SERVICES

The WHO Framework on Integrated People-Centered Health Services proposes five interdependent strategies for the development of responsive people-centered health systems that deliver high-quality, safe, and acceptable services for all. The below strategies are synergistic, a lack of progress in one area may undermine progress in another.

- ▶ **Empowering and engaging people and communities** - This strategy aims to empower individuals (including underserved and marginalized groups) with the opportunities, skills, and resources to make decisions about their own health and be empowered and engaged users of quality health services. It aims to enable communities to be actively engaged in co-producing healthy environments for individuals and be capacitated to delivery informal care that improves the health of communities (training and networks for community health workers, social participation, community delivered care).
- ▶ **Strengthening governance and accountability** - This strategy aims to strengthen governance using a participatory approach to policy formulation, decision-making, and performance evaluation at all levels of the health system. To reinforce good governance, a robust system for mutual accountability across stakeholders and a people-centered incentives system should be in place.
- ▶ **Reorienting the model of care** - This strategy calls for a people-centered approach to primary health care for the design and delivery of efficient and effective services that are holistic, comprehensive, and sensitive to social and cultural needs and preferences.
- ▶ **Coordinating services within and across sectors** - This strategy leverages multisectoral and intersectoral partnerships and the integration of health providers within and across settings and levels of care to promote care coordination. Coordination focuses on improving the delivery of care to better respond to the needs and demands of people.
- ▶ **Creating an enabling environment** - This strategy involves creating an enabling environment to bring all stakeholders together to transform all of these strategies into an operational reality. In order to effect change, this task involves a diverse set of processes in the domains of leadership and management, information systems, quality improvement methods,

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workforce development, legislative and policy frameworks, and health financing and incentives.

The policies and interventions that stakeholders adopt to achieve the realization of these strategies are context-specific, and as such will need to be developed according to the local context, values, and preferences of the country at the national, regional, and local level. An integrated people-centered approach to service delivery is essential for the achievement of five elements fundamental to universal health coverage:

- ▶ **Equity in access** - Everyone has access to the quality services they need everywhere, every time.
- ▶ **Quality** - Care is safe, effective, timely, and responsive to a comprehensive set of needs at the highest possible standard.
- ▶ **Responsiveness and participation** - Care is coordinated around people's needs and preferences and engages people as equal partners in their health affairs.
- ▶ **Efficiency** - Services are cost-effective and achieve an optimal balance of health promotion and in-and-out patient care to avoid duplication and waste of resources.
- ▶ **Resilience** - Health actors, institutions, and populations are capacitated to prepare for and effectively respond to public health crises.

More information on the Framework on integrated, people-centered approach, including the implementation approach and the role of stakeholders, can be accessed [here](#).

**What it is****CONTINUITY**

What others have done

How to get started

How to succeed

Continuity refers to a long-term healing relationship between a person and his or her primary care provider or care team over time. There are at least three types of continuity considered to be important for primary care (7): Relational continuity - An ongoing therapeutic relationship between a patient and one or more providers; Informational continuity - The use of information on past events and personal circumstances to make current care appropriate for each individual; and Management continuity - The extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent. It can also be thought of as a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs.

**WHAT IS CONTINUITY AND WHY IS IT IMPORTANT?**

Continuity of care refers to the long-term healing relationship between a person and his or her primary care provider or care team over time. (3) Continuity can contribute to patient-provider trust, patient satisfaction, and communication, and is associated with improved preventive care and reduced inpatient utilization. (3-5) There are at least three types of continuity considered to be important for primary care (3,5,6): (1) Interpersonal or relational continuity - an ongoing, therapeutic relationship between a patient and one or more providers (made up of longitudinal continuity with one provider, or continuity with a regular team); (2) Informational continuity - the use of information on past events and personal circumstances to make current care appropriate for each individual; and (3) management continuity - the extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent. Continuity can also be thought of as a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs (known as flexible continuity, or as a property of care coordination).

Listed below are two central questions stakeholders should consider when planning and implementing system reforms and interventions that prioritize continuity:

- ▶ What are some challenges to continuity of care?
- ▶ In what way can systems ensure continuity of care in service delivery?

As is the case for the other topics in this module, continuity should be prioritized alongside first contact accessibility, coordination, comprehensiveness and person-centeredness to improve high-quality primary health care delivery for all. (7,8) In particular, better coordination follows from continuity for the seamless transition of patient care across settings and providers. (3) In order to achieve effective and sustainable systems that promote these core functions of high-quality primary health care, stakeholders must invest in both system redesign and additional resources, discussed in greater depth in the following subdomains.

**WHAT ARE SOME CHALLENGES TO CONTINUITY OF CARE****BUILDING A SKILLED WORKFORCE**

In order to meet population health needs and maintain relationships over time, countries must invest in a workforce with the knowledge, skills, and motivation to effectively deliver primary care services. Some challenges in maintaining a high-quality workforce may include ineffective posting and transfer to rural or remote areas or migration of skilled workforce to urban areas and abroad, contributing to workforce shortages in areas the most deprived of high-quality services. (9) Strategies related to retaining, recruiting, and stationing (new) providers are often used to improve access to care due to geographic, financial, or other barriers. While investment in a health workforce is an essential

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component of health system strengthening, (10) it is important for stakeholders to consider the potential trade-offs between increasing access by expanding human resources and continuity of care. However, increasing the quantity of a workforce does not ensure continuity or the delivery of services that cater to population health needs. In order to ensure the delivery of high-quality services, stakeholders must ensure care is both accessible and continuous. Doing so requires investment in strategies, plans, and programs to develop a consistent workforce both capable and motivated to deliver person-centered care. (3,11) Continuity can be improved through longitudinal care relationships, which refers to the ongoing pattern of care that occurs in an accessible and familiar environment from a consistent team of providers. (5) For this reason, it is important for stakeholders to invest in developing and capacitating a workforce to build and sustain relationships with people over time.

Strategies to effectively and equitably retain, recruit, and station providers - commonly called Posting and Transfer (P&T) - include: expanding medical education and in-service training targeted at specific cadres or regions; strengthening primary and rural care programs in existing institutions; providing incentives and support for providers to work in rural areas, public facilities, or primary care settings; instituting mandatory civil service in these same areas; training facility-based providers from underserved areas who are more likely to return or remain in these areas; and developing methods for improving provider motivation and satisfaction such as supportive supervision, career development, adequate workload and facility infrastructure, and continuing education, so as to promote provider retention. (12-15) More information on provider motivation is included in the provider motivation module.

It is also important for stakeholders to consider incentives or specific training that can help providers more successfully carry out their responsibilities in underserved areas that often experience challenges in workforce retention. For instance, if countries are struggling with posting and/or retention in rural areas, they could increase salaries or institute loan repayment for providers who serve in these areas. Non-financial support that is important to consider may include cultural or language training and systems for providing in-service training and professional growth. (16)

## WEAK COMMUNICATION AND INFORMATION SYSTEMS

It is important to ensure that strong information and communication systems are in place within and across levels of care to ensure a patient's information is available at the right place and right time to minimize disruptions in their care experience.(3) Adequate transfer of patient information within and across levels of care (both up and down-referrals) is essential for the timely delivery of effective services and care coordination (17,18) To facilitate informational continuity, information systems should produce reliable, complete, and timely information that ensures interoperability from a wide range of data sources. (3) It is important that information systems are aligned with national priorities and local needs with a clear policy direction and financial support to ensure their successful implementation and ongoing functionality. (19) More information on strengthening information systems can be found in the section, **In what ways can systems ensure continuity of care in service delivery: informational continuity**, the module on [Information Systems Use](#), and in **Information Systems** (forthcoming).

## ACCESSIBILITY AND CONVENIENCE

While patient-provider continuity is one of the hallmarks of primary care and a priority to many patients (20), the degree to which patients prioritize continuity often depends on the individual and the nature of their health problem. (21,22) For example, timely access, or the ability to secure an appointment quickly, (20) may be of higher priority to patients with acute conditions and more likely to increase patient perceptions of managerial continuity. (17,22,23) Long waiting times that result in an inability to secure an appointment with a primary care provider (in a timely manner) increase a patient's likelihood of visiting the emergency room for non-emergency condition. (24) This often leads downstream consequences for facilities and patients, including overcrowding of emergency

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facilities, longer wait times in emergency departments for patients with urgent needs, and poor-continuity of care. (20)

Given the tendency for patients to prioritize speed and convenience over continuity in their care-seeking behavior, (22,23) especially for management of acute or minor problems, (25,26) it is important for primary care systems to manage the often conflicting metrics of timely access and patient-physician continuity. (20) [Open-access scheduling](#), or “same-day scheduling” is one strategy that has been demonstrated to increase patient satisfaction and perceived accessibility and improve efficiency and continuity of care. (27-29) However, in settings with limited resources, there is often an “either/or” trade-off between timely access and continuity rather than a balance of the two. Developing high-quality systems that improve continuity of care without compromising timeliness (or vice versa) requires investment in both system redesign (around the fundamentals of first-contact access, coordination, comprehensiveness, person-centeredness and continuity) and sufficient financial, physical, and human resources to sustain these systems.

The strain on resources (financial, physical, human, technical) that results from a higher demand for primary care services (more patients accessing care) highlights the broader tension between access and continuity. It is often hard to improve both access and continuity at the same time. Doing so requires added investment in developing and sustaining resources (financial, physical, human, technical) - discussed above in **workforce retention and sustainability** - to minimize disruptions in the provision of high-quality care. Strategies that work to improve access and promote patient-provider continuity involve enhancing patient access and balancing the timely and equitable delivery of high-quality services. Related strategies for improvement may include creating [contingency plans](#), decreasing demand for appointments through [capacity allocation strategies](#), and enhancing patient access and relational continuity through [empanelment structures](#). Strategies to bolster facility-based resources should enhance continuity and access through team-based coordinated care (including the investment in training mid-level providers and community health workers) and proactive outreach. (30,31) More resources can be found the [Safety Medical Net Home Initiative](#) and the [Institute for Healthcare Improvement](#) regarding strategies and tactics to enhance patient access and balance supply and demand on both a short and long-term basis.

## POORLY MANAGED CARE TEAMS AND DISCONTINUITY IN PATIENT-PROVIDER RELATIONSHIPS

Multidisciplinary team approaches are increasingly being incorporated to support primary care practices in LMICs. (32) Teams with a diverse set of skills and knowledge are thought to be beneficial for complex tasks, better decisions, more creative solutions (33-35), and cross-disciplinary information sharing to foster more comprehensive care. (36) Strong patient-provider relationships are essential to continuity of care, however, multidisciplinary care teams may not ensure the level of continuity relative to traditional patient-primary care provider relationships. (34) When patients are seen by multiple providers without well-communicated transitions between team members, care teams may pose a barrier to continuity and the development of longitudinal patient-provider relationships. (34,37-39)

While multidisciplinary care teams hold promise for improving primary care quality, it is important for this value to be embraced by patients to ensure relational continuity and effective longitudinal management of care. (34) For primary care systems looking to incorporate team-based approaches to care delivery, it is important for primary care teams to be well-managed and thoughtfully communicated to patients in alignment with their needs and preferences. (34,40) More information on team-based care organization can be found [here](#).

## IN WHAT WAYS CAN SYSTEMS ENSURE CONTINUITY OF CARE IN SERVICE DELIVERY?

### INFORMATIONAL CONTINUITY

Information continuity refers to the capacity of a system to ensure that the information relevant to a patient's care is made available to both the patient and provider at the right place and the right time, throughout a patient's care experience. (3) Well-designed information systems empower and engage patients, improve communication among team members, and improve continuity and coordinated care. (41,42) Information systems should produce reliable, complete, and timely information that ensures interoperability from a wide range of data sources and continuity of patient information. (3) To ensure information continuity, robust information and communications technology should be in place with systems for documenting care information, patient context (including family and patient medical histories and geographic information), and patient preferences. (43,44) Health information systems (HIS) are an essential component of health system strengthening. (10) It is important that HIS align with national priorities and local needs and that their implementation is coupled with sufficient investment in infrastructure and training to promote their successful implementation. (19) More information on the utilization of information systems to support coordinated and continuous care can be found in [information systems use](#).

### Patient medical records

Providers rely on the capacity of information systems to store reliable, authoritative, usable, understandable, and comparative data for making clinical decisions at the point of care and across time. (10) It is essential that these systems are well-capacitated to store and manage patient medical records in order to effectively identify, track, and respond to the needs of patients across the continuum of care. Individual level data (in the form of patient medical records) should capture information about the patient's profile, health care needs, treatment and other information. (10)

In many countries, portable medical records (such as booklets or cards) are utilized to document patient information. While portable records can help enable informational continuity (if no centralized record-keeping systems are in place), in the long-run these are fragile and unreliable mechanisms for maintaining patient records. To enable informational continuity, the care records of a patient should be easily accessible to all providers involved in their care through standardized clinical protocols and clearly defined referral networks. (43,45,46) To enable better monitoring, supervision, and decision making medical records systems should be interoperable and designed to collect information on a broad spectrum of patient information, taking into account the social determinants of health. From a technical perspective, like CRVS, medical record systems may be paper-based manual systems or electronic depending on the country-context. If paper-based, facilities should take steps to establish appropriate record keeping practices (responsive to changes in the volume of records) to limit errors such as duplication and incomplete data, coupled with staff training, monitoring, and supervision. Files should be able to be readily retrieved to mitigate barriers to timeliness and continuity of care. (47,48); (18) Stakeholders can find more information on developing effective and efficient medical records systems in the World Health Organization's [Medical Records Manual: a Guide for Developing Countries](#).

### Civil registration and vital statistics systems

Civil Registration and Vital Statistics systems record statistics on vital events, such as births, deaths, marriages, and divorces and give individuals a legal identity. CRVS systems should be comprehensive and aligned with international standards for the collection of reliable and continuous data on births, deaths, and causes of death. (49) While not essential for the keeping of medical records, CRVS systems help to enable informational continuity by giving patients a unique identifier that health information systems can use to identify, track, and respond to the needs of patients and population. In addition, countries can use data generated from CRVS to increase the health information system's capacity for data collection, synthesis, analysis, and validation (such as CRVS data on child mortality)

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and accordingly strengthen system performance. (10) CRVS systems may be paper-based or technology driven. In many LMICs, especially those facing resource constraints, CRVS systems have remained largely paper-based and manual. However, the arrival of new technologies in resource-constrained environments, notably mobile phones, creates an enabling environment for countries to transition to more efficient and effective technology-based information systems.

Accordingly, to promote the development of CRVS systems that are accurate, comprehensive, accessible, and interoperable, countries should work to move from paper-based to automated systems, in which digitized information can be stored, sorted, manipulated and redistributed and checked for accuracy at high speeds and minimal cost. (50) Developing an efficient and effective CRVS system based on a well-functioning technology platform requires significant political commitment, public trust, financial support, and coordination across sectors. (51) In the interim of this transition, paper-based systems should ensure well-organized storage and management systems are in place to store, file, abstract, archive, and retrieve records. (52) More information on Scaling up CRVS and leveraging technology to transition from paper-based to automotive systems can be found in the [Global Scaling Up Investment Plan](#) prepared by the World Bank Group and the World Health Organization. Additional information on developing robust information systems, including CRVS systems, will be available in the inputs module on *Information Systems*, forthcoming.

## MANAGEMENT CONTINUITY

Management continuity can be thought of as a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs (known as flexible continuity, or as a property of care coordination). (3) In order to achieve continuity, services should be delivered in a complementary and timely manner and ensure a sense of predictability and security about the future of care for both patients and providers. Shared longitudinal care plans - a patient-centered holistic, dynamic, and integrated plan that documents disease prevention and treatment goals and plans and reflects a patient's values and preferences - can help to facilitate management continuity and coordinated care (3,43) Goals should be met across a broad range of services (if necessary) and flexible in adapting care to changes in an individual's needs and circumstances. For the management of patients with complex conditions, management continuity is enhanced enhanced through proactive, regular monitoring to ensure goals adapt to changes in an individual's changes in needs and circumstances. (3) (46) More information on [shaping patient-centered longitudinal care plans](#) across settings and levels of care can be found [here](#).

As patients transition across care levels and sites, it is important to prioritize continuity of care across sectors through effective coordination and standardized mechanisms. Improving management continuity will require significant investment in resources and systems that promote continuity and coordination, including robust information systems and a diversified and proactive workforce. Informational continuity (use of standardized care plans and diagnostic protocols and availability of actionable information) and coordinated information systems use are critical components of interoperable health information technology structures. To facilitate continuity across providers and facilities and interoperability between systems, standardized care plans and diagnostic protocols should be in place. (46) Electronic health records (EHRs) provide a useful means to help improve communication and coordination in health systems to achieve health and wellness goals throughout a patient's care experience. In systems with a significant number of non-facility based providers (community health workers, mobile health teams), it is important to integrate facility and community-based records into records systems (ie [MOTEC suite](#)) to promote informational and management continuity. More information on achieving an interoperable health information technology structure to improve management continuity can be found [here](#).

## INTERPERSONAL OR RELATIONAL CONTINUITY

While informational and management continuity ensure the provision of longitudinal information about a patient and a consistent care experience, these types of continuity do not directly address the nature of the relationship between the patient and provider. Relational continuity bridges the

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past, current, and future needs of a patient through the expectation of ongoing relationships with providers and is essential for the concept of person-centered primary care. (3,11) Relational continuity can be improved through longitudinal care relationships, which refers to the ongoing pattern of care that occurs in an accessible and familiar environment from a consistent team of providers. (5) Fostering a predictable and coherent environment for both providers and patients promotes patient-provider trust and communication as well as patient satisfaction. (3-5) To promote relational continuity, facility managers should facilitate a collaborative space for patients and providers to create management plans and protocols that reflect a patient's needs and preferences. (3,53,54) To promote active listening and accountability, managers should strive to build and retain a consistent core staff (3) that share a similar language and values to their target community. (55) More information on promoting patient-provider respect and trust can be found [here](#).

What it is

**WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE CONTINUITY?**What others  
have doneHow to get  
startedHow to  
succeed**BIHAR, INDIA - CONTINUUM OF CARE SERVICES (CCS)**

The Saharsa district in Bihar, India is marked by high levels of poverty and barriers to accessing quality health services. In efforts to increase access to vital maternal, newborn, and child health including nutrition (MNCHN) services, this area is serviced by 35 health sub-centers and a vast network of Frontline Health Workers (FLWs) and supervisors. However, the effective delivery of these services has been historically challenged by a lack of coordination among the health workforce and limited capacity and resources (including a lack of paper-based tools and job aids) to plan and deliver comprehensive care. In 2012, the Continuum of Care Services (CCS) was launched as part of a collaborative effort to improve the capacity of FLWs to deliver essential and quality MNCHN services across the continuum of care. The CCS is a comprehensive mobile health tool with a suite of modules built upon the government's Integrated Family Health Initiative's framework for MNCHN service provision. (56) The CCS incorporates various checklists, diagnostic assessments, records, and counseling support aids to better equip the health workforce with the tools and knowledge to deliver appropriate care. These aids are differently designed to meet the needs of women and children based on their respective stages of pregnancy, delivery, post-delivery and newborn care. The type of care patients receive at each stage of care is unique to their history and plans for the future, promoting the delivery of person-centered services.

To promote better coordination and continuity among caretakers, the content within the tool is specific to the cadre of the health worker, corresponding to their roles and responsibilities within the frontline health management structure. In addition, the tool supports better supervision and coordination mechanisms through task scheduling, performance monitoring, and technical support (to prevent the disruption of information flow), and a built-in feature for health workers in the same catchment area to share relevant cases. (56) The use of the tool by FLWs has made strides to increase the number of women accessing critical care at the right time, with a demonstrated increase in contact by a FLW for the appropriate management of conditions after the first 24 hours of delivery from 6.7% to 59.5% in the first year of its adoption. Additionally, it has improved the quality and experience of care, including the comprehensiveness of home visits. In light of the successes of the CCS, CARE India is proposing to scale the system in Bihar and pursue further integration with the Mother and Child Tracking System, India's national database to track pregnancies and newborns. More information on the CCS can be accessed [here](#).

**PORTUGAL - PORTUGUESE NATIONAL NETWORK FOR INTEGRATED CONTINUOUS CARE (RNCCI)**

The Portuguese National Network for Integrated Continuous Care (RNCCI) was introduced in 2007 as a joint initiative of the Ministry of Health and Social Solidarity to provide integrated and continuous care to dependent people. The network cuts across private, public, and nonprofit sectors to provide long-term, comprehensive and coordinated services, with a focus on community-based care. (57) The RNCCI is designed to provide patients and providers with continuous health monitoring information and support through the use of an online data management system (GestCare CCI) that records referrals, admissions, transitions, waiting time for admission, and the outcomes of needs assessments. (58) GestCare CCI supports smoother care transitions and simplifies tracking the patient across settings of care, promoting better information and management continuity between relevant care providers. (59)

The RNCCI is decentralized and organized into three levels of coordination at the national, regional, and local/provider level with quality indicators collected at each level through compulsory data submissions. To promote better case management, providers across the RNCCI network, including hospital discharge management teams, primary health care centers, local coordination teams, and regional and national coordination teams have access to the information in GestCare CCI. (58)

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Individuals within the RNCCI undergo a needs assessment with comprehensive care teams to create a personalized care plan. The care plan and results of the needs assessment are documented in GestCare CCI and coordinated across members within the care team to promote continuity of care across the range of providers involved in an individual's care. (58)

What it is

What others  
have doneHow to get  
startedHow to  
succeed

## WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for determining whether continuity is an appropriate area of focus for a given context and how one might begin to plan and enact reforms:

### WHAT INFORMATION SYSTEMS ARE IN PLACE (IF ANY) TO ENSURE CONTINUITY OF PATIENT INFORMATION ACROSS CARE ENCOUNTERS AND LEVELS OF CARE?

Continuity of patient information across levels of care promotes better care coordination and longitudinal continuity of care. It is important to ensure that strong information systems are in place, including civil registration and vital statistics and electronic health records systems, within and across levels of care to ensure a patient's information is available at the right place and at the right time to minimize disruptions in their care experience.

### HOW DOES TIMELINESS AFFECT CONTINUITY OF CARE FROM A PATIENT PERSPECTIVE? ARE PATIENTS OFTEN DETERRED FROM SEEKING CARE FROM THE SAME PROVIDER DUE TO ACCESSIBILITY?

The degree to which patients prioritize continuity often depends on the individual and the nature of their health problem. There is a tendency for patients to prioritize speed and convenience over continuity in their care-seeking behavior, especially for the management of acute or minor problems.<sup>(22,23)</sup> Long waiting times that result in an inability to secure an appointment with a primary care provider in a timely manner increase a patient's likelihood of visiting the emergency room for a non-emergency condition. It is important for primary care systems to manage the often conflicting metrics of timely access and physician-continuity to enhance patient access and balance the timely delivery of high-quality services from the patient perspective. Developing high-quality systems that improve continuity of care without compromising timeliness (or vice versa) requires investment in both system redesign (around the fundamentals of first-contact access, coordination, comprehensiveness, person-centeredness, and continuity) and sufficient financial, physical, and human resources to sustain these systems.

### IF TEAM-BASED CARE IS UTILIZED, WHAT COMMUNICATION STRATEGIES ARE IN PLACE TO ENSURE THAT PATIENTS HAVE STRONG RELATIONAL CONTINUITY BETWEEN MEMBERS OF THE CARE TEAM?

When patients are seen by multiple providers without well-communicated transitions between team members, multidisciplinary care teams may pose a barrier to continuity and the development of longitudinal patient-provider relationships. For primary care systems incorporating team-based approaches to care delivery, it is important for primary care teams to be well-managed and thoughtfully communicated to patients in alignment with their needs and preferences in order to promote continuity. More information on strategies for effective team-based care organization can be found [here](#).

### ARE THERE ANY TOOLS IN PLACE THAT CAN HELP PROMOTE MANAGEMENT CONTINUITY SUCH AS STANDARDIZED CARE PLANS AND DIAGNOSTIC PROTOCOLS?

As patients transition across care levels and sites, it is important to prioritize continuity of care across sectors through effective coordination and standardized mechanisms. Improving management continuity will require significant investment in resources and systems that promote continuity and coordination, including robust information systems (EHRs, CRVS) and a diversified and proactive workforce. To facilitate continuity across providers and facilities and interoperability between

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systems, standardized care plans and diagnostic protocols should be in place and backed by strong information systems. In systems with a significant number of non-facility providers (community health workers, mobile health teams), it is important to integrate facility and community-based records into records systems (ie [MOTTECH suite](#)) to promote informational and management continuity.

### **HOW ARE FACILITY MANAGERS PROMOTING A CULTURE OF INTERPERSONAL CONTINUITY AMONG PROVIDERS AND PATIENTS?**

Interpersonal continuity bridges the past, current, and future needs of a patient through the expectation of ongoing relationships with providers and is essential for the concept of person-centered primary care. Interpersonal continuity can be improved through longitudinal care relationships, which refers to the ongoing pattern of care that occurs in an accessible and familiar environment from a consistent team of providers. To promote interpersonal continuity, facility managers should facilitate a collaborative space for patients and providers to create management plans and protocols that reflect a patient's needs and preferences. To promote active listening and accountability, managers should strive to build and retain a consistent core staff that share a similar language and values to their target community.

## WHAT ELEMENTS SHOULD BE IN PLACE TO SUPPORT EFFECTIVE IMPROVEMENTS?

### INFORMATION SYSTEMS & INFORMATION SYSTEMS USE

Continuity of care relies on information systems with broad capacities to track and manage the health of a patient. It is important to ensure that strong information systems are in place, including civil registration and vital statistics and electronic health records systems, within and across levels of care to ensure a patient's information is available at the right place and the right time to minimize disruptions in their care experience. (3) Information systems should produce reliable, complete, and timely information that ensures interoperability from a wide range of data sources and continuity of patient information. (3) The effective use of information systems empowers and engages patients and improves communication among team members to promote continuity of care. (41,42,60) Interoperability of data management systems across facilities and services is an essential functionality to ensure that information systems can effectively collect, analyze, and share critical information.

### EMPANELMENT

By establishing a point of care for individuals and simultaneously holding providers and care teams accountable for actively managing care for a specific group of individuals, empanelment can promote a consistent care experience. Empanelment also provides a population denominator so stakeholders can more easily interpret data, track performance, and effectively plan services to meet population needs and preferences across the care continuum. To further promote continuity in patient-provider relationships, empanelment structures should strive to build and retain a consistent core staff that share a similar language and have a strong understanding of the cultural practices and values of their target community.

### QUALITY MANAGEMENT INFRASTRUCTURE

As patients transition across levels and sites of care within and beyond the health sector, it is important for quality management infrastructure to be in place to facilitate a continuous care experience. To facilitate the continuous delivery of high-quality primary health care across providers and facilities, a national quality improvement plan that integrates standardized care plans, diagnostic protocols, training programs, and accreditation systems should be in place.

### FACILITY ORGANIZATION AND MANAGEMENT

To promote continuity in service delivery, the facilities that deliver this care must be well-organized and well-managed and accompanied by a skilled and motivated workforce, inputs, infrastructure, and information systems. Effectively run facilities should include multidisciplinary teams, routine collection and use of information systems, and the capabilities of managers to oversee, support, and enforce processes. Additionally, facility managers should promote the value of continuity to providers and ensure that system are in place to enable continuous care.

### PATIENT-PROVIDER RESPECT AND TRUST

Respect for patients and providers is central to the provision of effective primary health care services. A few important components of respectful care are empathy and active listening. Respect and trust between providers and patients can improve communication and provider motivation and contribute to the formation of continuous relationships over time. Fostering a predictable and coherent environment for both providers and patients promotes patient-provider trust and communication as well as patient satisfaction, central contributors to relational continuity.

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