The Family Continuity of Care Contract

David Driggers, MD, Carolyn Fink, RRA, and Charles Huff, MD
Casper, Wyoming

Continuity of care has been defined as a contract between a patient and physician for medical care. This study looks at continuity of care in a community family practice residency program before and after office contact has been made with at least one member of the family by the assigned physician. It is assumed that during such a visit a contract for care of the family is made. Using this premise, continuity of care increased significantly when the different resident levels and faculty were compared over a 2.5-month period. It seems reasonable to measure the continuity of care provided an assigned family only after a contract has been made. This contract should be accomplished in an initial intake interview or during the initial office contact with the assigned physician.

Continuity of care has been described by primary care physicians as being an important concept in the delivery of modern health care. Recently continuity of care has been defined as an attitudinal contract between the physician and patient. This contract can be for longitudinal care, as seen in private practice and a family practice residency, or for care given during a brief illness.[1] The difficulty in objectively measuring continuity of care with these various subtypes is apparent. It is even more difficult to measure continuity of care if a family is assigned to a physician before a contract is made. In such a situation, when does continuity of care begin?

This study compares the experience in a busy family practice residency between the different resident levels and faculty before and after a family continuity of care contract has been made. It is assumed that when at least one member of an empaneled family visits the assigned physician, then a contract for care has been made between the physician and that family. This should be similar to a contract for care that is made during an initial intake interview. For the purposes of this study, continuity of care is defined as care by the assigned physician extending across periods of illness and well-being but not across major life changes (subtype T).[1]

Methods

The University of Wyoming Family Practice Residency at Casper, Wyoming, is a community-based residency with seven third-year, seven second-year, and eight first-year residents. Regular clinics are scheduled two, three, and four times per week for the first-, second-, and third-year residents, respectively. Nonclinic hours are covered by residents on a rotational basis. The Family Practice Inpatient Service coordinates care of clinic patients admitted to the hospital. Residents

From the Family Practice Residency Program, University of Wyoming, Casper, Wyoming. Requests for reprints should be addressed to Dr. David A. Driggers, 1522 East "A" Street, Casper, WY 82601.

0094-3509/82/090471-03$00.75
© 1982 Appleton-Century-Crofts

Table 1. Overall Continuity of Care				
Provider	Total Visits	Visits with Assigned Physician	Visits with Other Physicians	Percent Continuity of Care
First-year resident	748	341	407	46
Second-year resident	1,128	661	467	59
Third-year resident	980	440	540	45
Faculty	495	343	152	69
Total	3,351	1,785	1,566	53

are strongly encouraged to manage their own inpatients. Resident time away from the program, although complying with Residency Assistance Program guidelines,[2] includes a rural practice rotation, electives, vacations, and meetings.

Patients are empaneled into a resident or faculty member's practice after completing an application form with the receptionist. This might be accomplished at the same time medical care is needed. Because of time and monetary constraints, no intake interview is performed. However, the family members are seen as soon as possible by their assigned physicians. At present, 3,316 families are empaneled, and a total of 9,516 patients are cared for at the residency center.

From July 1, 1981, through September 10, 1981, all inpatient and outpatient encounters were coded on a computerized billing form and stored on computer file. Data were then examined for continuity.

Results

As noted in Table 1, a total of 3,351 patients were seen during this period. Fifty-three percent (1,785/3,351) of the total patient encounters were seen by the assigned physician. The greatest number of patients were seen by the second-year residents, whereas the greatest continuity was provided by the faculty.

After a contract for care had been made, 2,620 patient encounters resulted in an overall continuity of care of 63 percent (1,785/2,620) (Table 2). Statistical analysis was then made of the data, comparing the first-, second-, and third-year residents and faculty experience with these two populations. Percentile differences are noted in Tables 1 and 2. There was a statistically significant difference by chi-square ($P < .01$) between both populations. Once again, the faculty achieved the highest overall continuity of care (84 percent).

Discussion

The concept of continuity of care in primary care practice has been extremely difficult to define and implement in the everyday practice of medicine. Part of the difficulty arises in different definitions of continuity of care, ranging from a longitudinal care to the continuity of care provided during one limited illness.[1] Previous studies in family practice programs have attempted to measure the continuity of care in different ways.[3-7] In this study, longitudinal inpatient and outpatient continuity of care was measured before and after a continuity of care contract was made.

Other studies have shown higher continuity of care than was shown in this study,[4,6,7] possibly because other studies used different numbers of patients, residents, and faculty, and this study included care provided while the regular physician may have been away from the residency. The most interesting difference may be the lack of an intake interview. The obvious advantage of such an interview is the establishment of an attitudinal

Table 2. Continuity After Contract for Care Has Been Made

Provider	Total Visits	Number of Visits With Assigned Physician	Number of Visits Not With Assigned Physician	Percent Continuity of Care
First-year resident	528	341	187	65
Second-year resident	946	661	285	70
Third-year resident	738	440	298	60
Faculty	408	343	65	84
Total	2,620	1,785	835	68

contract for care[1]; however, the monetary and time constraints on a community-based family practice program, as well as the individual family, also must be weighed. The lack of such an interview results in the possibility of a patient seeing several physicians prior to seeing their empaneled physician. Of additional concern is the physician's ability to form a contract with the family merely through treating an ill family member. Although not ideal, many family practice programs operate without the intake interview contract, and this has an obvious impact on the continuity of care.

The low number of patients and continuity of care provided by the third-year residents was a direct result of rotations away from the residency. This information supports the need for criteria established by the Family Practice Residency Assistance Program for off-site rotations.[2] Need exists for completion of similar studies at other institutions to see what effect outside rotations have on continuity of care.

Regardless of the many variables seen in this program, once a continuity of care contract had been made with at least one member of the family, the continuity of care for that family improved dramatically ($P < .01$). This was especially true among the first-year residents. It seems reasonable, therefore, to measure continuity of care of an assigned family only after a care contract has been made. This may be accomplished either with an intake interview or upon initial contact between the physician and the empaneled family.

Future studies of continuity of care should assure that a contract for care has been made prior to an evaluation of medical outcome. It seems reasonable that this be a minimum starting point for any such study and, indeed, for routine care of the family.

Conclusions

The family continuity of care contract can be made by the assigned physician only after initial contact with any one member of the empaneled family. This provides an attitudinal contract between the physician and family that should lend itself to improved health care as well as objective evidence for continuity of care.

References

1. Banahan BF Jr, Banahan BF III: Continuity: An attitudinal contract. Semin Fam Med 2:88, 1981
2. Family Practice Residency Assistance Program Criteria. Kansas City, Mo, Residency Assistance Program Project Board, 1979, p 8
3. Hadac RR, Smith CK, Gordon MJ: Can continuity of medical care be taught? J Med Educ 54:525, 1979
4. Rogers, J, Curtis P: The achievement of continuity of care in a primary care training program. Am J Public Health 70:528, 1980
5. Boyle RM, Rockhold FW: An analysis of returning patients in family practice. J Fam Pract 8:1029, 1979
6. Patton RC, Friberg R: Measuring continuity of care in a family practice residency program. J Fam Pract 11:67, 1980
7. Curtis P, Rogers J: Continuity of care in a family practice residency program. J Fam Pract 8:975, 1979