The Role of Continuity of Care in the Management of Chronic Disease

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Continuity of care is typically defined as a longitudinal relationship between a patient and a personal physician or health care team.1 It is an ongoing health care management approach that ensures involvement of patients and their physician-led care team in a cooperative effort towards the shared goal of high-quality, cost-effective medical care.2 Continuity of care is a core element and primary objective of family medicine and is consistent with quality patient care. It helps family physicians gain their patients’ confidence and enables them to be more effective patient advocates. Continuity of care is associated with improved preventive and chronic care, better patient and clinician experience, and lower costs.3

Continuity of care is influenced by several factors, including demographic, patient and healthcare professional, patient-healthcare professional relationships, inter-professional, and organizational factors. In a US study,4 the main factors contributing to the maintenance of continuous care were patient familiarity with the physician, physician knowledge of the patient, patient satisfaction with care received, and patient confidence in the physician. However, the location of practice appeared to be the reason for consulting a physician rather than continuing the relationship with a physician. Another study of rural Australian inhabitants showed that social accessibility or acceptability considerations were more significant than geographical proximity in the choice of rural residents to consult a particular doctor.5 Older adults, in particular, attributed more significance to the acceptability and continuity of care. Geographical proximity ranked highest for young and middle-aged people and men living in isolated communities. Factors affecting the continuity of care may vary depending on the environment, such as the country or medical system.

Higher continuity of care can improve patient satisfaction, clinical indicators, and the cost of care in patients with diabetes.6 A previous study of Korean diabetes patients showed that women, the disabled, and people of low socioeconomic status living in rural areas have relatively lower continuity of care.7 In the present issue, Shin et al.8 investigated the association between continuity of care and patients, clinic workforce, and geographical factors among patients with diabetes using a Korean nationwide sample cohort. In this study, the continuity of diabetes care was significantly higher in middle-aged patients who lived in metropolitan areas, did not have disabilities, visited an internal medicine or family medicine specialist, and lived close to their primary care providers.

In 2018, 13.8% of Korean adults aged ≥30 years had diabetes. However, only 28% of patients managed hemoglobin A1c levels of less than 6.5%. Despite its high prevalence, the control rate was not as high as expected. Considering previous studies, increasing the continuity of care in patients with diabetes may contribute to an increase in the unsatisfactory control rate of diabetes. Studies on continuity of care for patients with chronic diseases, including diabetes, are still lacking in Korea, and more diverse studies are needed.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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