

Continuity of care from the perspective of users

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Abstract *Continuity of care, in addition to ensuring improvement of the quality of care, contributes to the reduction of health costs. The objective of this study was to analyse the continuity of care in health units in the municipality of Évora (south of Portugal), from the perspective of users. This is across-sectional, exploratory and descriptive study with a quantitative approach, with a sample consisting of 342 users of health units. The instrument was a questionnaire adapted from English and Spanish studies. The results show that elements of continuity were identified in the different dimensions of the continuity of care - relational, management, information and some items of flexible continuity. Longitudinal continuity has the lowest values in nursing care. In conclusion, what stands out positively, and in its different dimensions, is relational continuity, in which most users recommend their family doctor and nurse to family and friends, and flexible continuity, which translates into reduced waiting times to be attended by a doctor or nurse and access to care. What stands out negatively is the weak involvement of the user in care by health professionals, in the dimensions of relational continuity.*

Key words *Patient care continuity, Primary Health Care, Community health services, Health*

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Introduction

In a context of uncertainty and rapid changes and, in the specific case of health, given the current pressure on costs, coordination between different healthcare providing organisations has increasing importance.

In the Portuguese health system, continuity of care is conceived as “*sequentiality, in time and in healthcare and social security systems, of integrated health and social support interventions*”¹.

Continuity of care ensures improvement in the quality of the care provided, contributes to a reduction in costs and is presented as a suitable strategy and a policy to be followed by health services. Users are vulnerable to experiencing loss of continuity when there are changes in health or when they move between healthcare organisations.

The objective of this study was to analyse the continuity of care in community health units of five municipalities in the district of Évora (south of Portugal), from the perspective of users.

The National Health Service (SNS) integrates the group of official services and institutions, which depend on the Ministry of Health (MS), with the objective of ensuring access to healthcare to all citizens, within the limits of financial, human and technical resources. The health system is made up by the SNS and all public organisations that organise activities of promotion, prevention and treatment in the health area and by all private organisations and all free professionals that agree with the former on the provision of all or some of those activities^{2,3}.

The health system is based on Primary Health Care (CSP), with this requiring to be situated within communities. It is the first level of contact with the SNS for individuals, family and community. In Portugal, the definition of the CSP issued by the Declaration of Alma-Ata (1978) is adopted, which considers it as “*essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination*.”⁴

In 2008, in Portugal, CSP was recognised as the central pillar of the health system, considering health centres (CS) as the first point of access of citizens to healthcare, having strengthened their role in the promotion of health and prevention of illness, providing care during illness and

connection to other services in the continuity of care, by reforming CSP. Other central objectives of this reform were to guarantee the access of the entire population to healthcare and the assignment of a family doctor to all citizens.

To formalise this in geodemographic terms, Health Centre Groups (ACES) were created, defining objectives and competencies for each of the units that came to form part of the health centres⁵.

In each ACES, there is also a Public Health Unit (USP), which functions as a health observatory of the geodemographic area of the different CS's and of a Shared Healthcare Resource Unit (URAP), which provides technical assistance services to citizens using USFs, UCSPs and UCCs, as can be seen in Figure 1.

In view of the ageing population and the subsequent typical profile of the elderly, a large part of which use CSP, the importance of integration and continuity of care stands out, its objective being to ensure that users, *depending on their specific situation, can access the type and intensity of care that they in fact need, at the right time and place*⁶.

Continuity of Care

Continuity of care is a right of citizens, which takes on even greater importance when they require multi-professional care/interventions di-

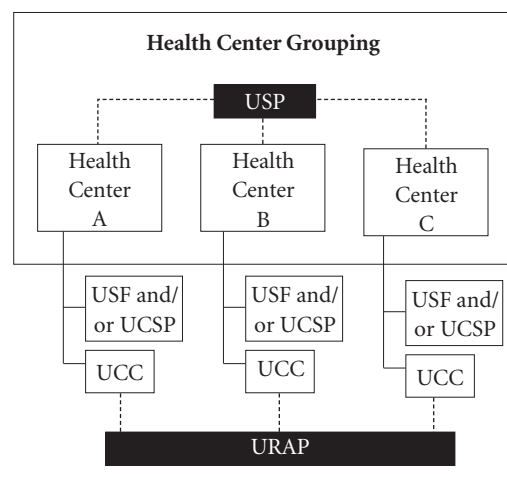


Figure 1. Organisation chart of community healthcare.

rected at chronic or complex situations of which they are carriers.

Continuity of care is believed to exist when it is provided in a complementary manner within a suitable period. Continuity refers to the implementation of care by different providers, in a coherent, logical and timely manner⁷.

The complexity of current health problems and efficient resource use require a multidisciplinary and inter-institutional approach, due to which the coordination between hospital health-care and CSP is crucial, thus enabling global intervention at the three levels of prevention. This coordination requires multi and interdisciplinary teamwork. In order for coordination to exist between the different levels of care, sufficient communication between professionals is essential⁸.

Continuity of care begins at the service where the person is attended, which results in the need to establish contacts and put into operation the early preparation of the discharge. In this context, the family is a fundamental link, which is why it is necessary to reflect on the information provided and way of doing it, given the state of vulnerability of the family⁹.

There are several benefits associated with continuity of care, namely a greater possibility of integration of the physical, psychological, social and economic dimensions; improvement of the relationship between users and care providers; reduction in the improper use of health services and an eventual reduction in costs. On the other hand, user satisfaction increases with the service, as well as that of the healthcare professional with his or her work¹⁰. The fragmentation of care, in turn, can result in treatment guidelines that are confusing for the user, with a strong probability of errors and duplications, inadequate follow-up, as well as a lack of preparation/information of the user and informal care providers. It is essential to reduce the asymmetry of information between users and healthcare providers, with the provision of more information to users of health services¹¹.

The sharing of clinical information can be an important means of supporting the provision and continuity of care, due to the possibility of exchanging information between professions from different levels of care, namely CSP and hospital care. Another determining factor will be the user's participation. Better informed users will also be users with a greater capacity for participation¹².

Information sharing between health services in Portugal is either non-existent or scarce. The

development of a model for information sharing and coordination of nursing information systems between hospital and CSP will allow for significant improvement, through continuity of care, of access to and the quality of nursing care provided¹³.

A study¹⁴ performed with the objective of analysing the criteria used for admission, routing and continuity of care to users at centres for psycho-social attention led to the conclusion that continuity of care was mentioned as a problem, possibly due to the difficulty of monitoring users in the community. Continuity of care at home is an innovative way of providing care. A study⁹ was performed for the purpose of understanding how to ensure continuity of care at home and the role of the nurse in building this continuity.

Another study⁸ sought to learn about strategies of partnership/collaboration between an in-patient service and CSP, with a view to improving the quality of care provided at a lower cost, concluding that continuity of care to children with oncological illness is practically non-existent. According to the author, coordination between services is very weak, lacks coherence and is highly unsystematic.

In order to develop strategies for continuity of care, health organisations must establish different organisational mechanisms, including: training, planning and decision making at the inter-institutional level through information systems, interdisciplinary clinical evaluation, protocols, follow-up and professional feedback¹⁵.

A study conducted between 2001 and 2004¹³, for the purpose of studying *relevant information for purposes of continuity of nursing care between different care contexts (Hospital and Health Centre)*, concluded that this information system was crucial in coordination between the different levels of care, contributing to communication and continuity of care. Relevant domains were identified for a *specific informational architecture for management of SIEs*; namely:

1. The structure of the model for sharing nursing information;
2. Information sharing strategies;
3. Protection and security in data processing;
4. Access to nursing information;
5. Data/information components to be integrated in the information sharing model.

Another study¹⁶ mentions that users refer to four dimensions of continuity: longitudinal continuity (regular follow-up of the patient and his or her illness over time); relational continuity (when users experience problems with their

diabetes, they might need an urgent consultation, or might want to speak with their family doctor or nurse to obtain advice); flexible continuity (which characterises the degree in which clinics manage to respond in the face of changes to the needs of users over time) and management continuity between levels (concerns with cross-boundary continuity, where the degree of coherence and coordination of care between different contexts of care and between different clinics is evaluated).

Yet another study¹⁷ identifies relational continuity, longitudinal, personal and continuous continuity as domains of continuity of care, which involve familiarity of one person with another in the context of a therapeutic relationship, with commitment and trust under which doctor and patient contribute to its creation and maintenance; and the management continuity, involving coordination and teamwork between carers and across organisational borders.

Access and relationship are important for continuity of care to users and their carers in CSP. Users recognise the value of continuity of care, which is more important for them in comparison with other aspects, such as quick access or a wide range of services. Continuity of care was considered in three main aspects¹⁸:

Information Continuity - where information, based on previous events and personal circumstances, is used to ensure continuity of care;

Management Continuity - where there is a consistent approach for managing the healthcare of a user, responding to his or her changing needs;

Relationship (also referred to as interpersonal) Continuity - where there is a continuous therapeutic relationship between a user and one or more care providers.

On analysing the valuation of continuity of care of users and identifying elements of (dis)continuity based on their experiences in healthcare services in Catalonia, three types of assistance-related continuity were identified, which are related to each other: of Relationship, understood as the user's perception of the relationship established over time with one or more caregivers; of Information, perceived as the user's perception of the availability, use, interpretation of information on preceding events to provide care suited to current circumstances; of Management, as the user's perception about the manner in which he or she receives care from different services, in a coordinated and complementary manner, without duplication¹⁹.

Each dimension of continuity in providing care refers to an important body of knowledge about the organisation and provision of health care, as a result of which it becomes interesting to learn the perceptions of users about the continuity of care. The different dimensions of continuity of care that were analysed in Chart 1.

In this study, it was decided to study continuity of care from the perspective of users, firstly because it has not been well studied, specifically among users under different types of conditions²⁰⁻²² and secondly, because there are differences between the perspective of users and professionals and policies in its perception²³. For users, continuity is usually related to the doctor-patient relationship, with satisfaction, with the quality of care and access to it²⁴. Several dimensions of continuity, such as interpersonal communication and specifically, trust and choice, are strongly valued by users. The importance of analysing and explaining the differences encountered between different users with different problems (for example those with and without chronic illness), and understanding whether they view continuity in the same way, through the use of studies, has been noted by several authors²⁵.

For health professionals and policies, continuity is essentially valued based on its impacts on the greater or lesser use of health services (in-patient or out-patient), in the limitation of access/use of specialised care and in the reorganisation of health services. Also in this context, the authors suggest the need to perform more studies that support the relationship and the dynamics that are established between continuity of care and the levels of use of health services²³.

Methodology

A cross-sectional, exploratory and descriptive study with a quantitative approach. The research instrument was based on a conceptual as well as objective framework, as well as two questionnaire models on continuity of care, which were consulted and for which authorisation for adaptation was obtained^{16,19}. The questionnaire is divided into six different parts, the first of which collects sociodemographic data, while the other five correspond to types of continuity (Relational, Information, Management, Longitudinal and Flexible Continuity).

After the preparation of the questionnaire, a pre-test was performed on a sample with characteristics similar to that of the population, having

Chart 1. Synthesis of the Dimensions of Continuity of Care that were analysed.

Relationship Continuity Dimension: Doctor/nurse - user relationship Dimension: Specialist-user relationship
Information Continuity Dimension: Transfer of clinical information
Management Continuity Dimension: Coherence/Consistency of care Dimension: Accessibility between different levels
Longitudinal Continuity
Flexible Continuity

performed the necessary adjustments.

The sample was made up by all users approaching the Community Health Units of 5 municipalities of the district of Évora (Alentejo Region - south of Portugal), in the month of May 2014, aged 18 years or older, whose cognitive capacities were maintained and who agreed to participate in the study (inclusion criteria), with a total of 342 users. This sample is not representative of the population.

The data was then processed statistically, using the *Statistical Package for the Social Sciences* (SPSS®) 18.0. Using the *Kolmogorov-Smirnov* test, it was observed that the data did not follow normal distribution, as it presented p values ≤ 0.05 , though there is homogeneity in the sample. In order to test the significance of independent variables that can influence dependent variables, the *One-way ANOVA* statistics test was used. On calculating the *Cronbach's Alpha* of the dimensions analysed, it was seen to vary between 0.768 and 0.979.

All ethical procedures were complied with (informed consent, confidentiality and anonymity), based on the Declaration of Helsinki on Ethical Principles in Research Involving Humans, and the Opinion of the Health Ethics Committee of ARSA no. 4/2012/CES was obtained.

Results

342 users of health units of the district of Évora, with ages from 19 to 101 years, responded to the questionnaire. Median age was 48.25 years, with a standard deviation of 17.348. 20.5% of the population is aged 65 years or more. With regard to gender, 29.8% are men and 69.6% women. The majority of users surveyed have more than 9

years of schooling (59%), and only 3.2% do not have any schooling. The family units are mainly made up of 2 people (31%). Single-person and larger (5 or more people) families represent the lowest percentages, 11.4% and 4.9% respectively.

Relating to health data, the analysis shows that almost all users have a family doctor (97.1%).

The data indicate that 34.5% of the users suffer from chronic illnesses. Among these, diabetes (35.6%) and high blood pressure (33.9%) stand out, while other illnesses show percentages that are much lower. Interestingly, 8.8% of these users mentioned suffering from more than one chronic pathology simultaneously.

The analysis performed reveals that there are statistically significant differences between biological and social variables, which characterise the users surveyed and some dimensions of the different types of continuity analysed, as will be seen below in the presentation of the results.

The results obtained relating to the different types of continuity allow us to observe that in terms of *relational continuity*, and with regard to the family doctor - user relationship, users have a positive view of the variables that make up this dimension, with percentages above 80%, except for the involvement of the user in decisions on the situation of health/illness and the fact that the family doctor takes the most important decisions on the user's treatment (Table 1).

Concerning the nurse-user relationship, the values of all the variables of this dimension are clearly lower than those observed relating to the doctor-user relationship, although they are above 50%, as can be seen in Table 1. In this dimension, as with the doctor-user relationship, with regard to nurses as well, the lowest values are reported in the involvement of users in decisions on their situation of health/illness (53.5%) and in decision making on the best treatment (51.8%).

In relation to the specialist doctor - user relationship, the analysis of the data indicates that the values obtained are close to the ones found in the doctor-user relationship, with a highly positive perception of this relationship. The variable showing the lowest values, but still above 75%, concerns information received from specialists.

Based on analysis of the data, what stands out is the fact that the highest values of the different variables of the nurse-user relationship do not even approach the lowest values obtained for the specialist doctor - user relationships.

The use of the *One-Way ANOVA* test allowed us to observe, in *relational continuity*, that there are statistically significant differences between

Table 1. Perception of users with regard to relational continuity.

Relational continuity	Yes %	No %	NR %
Dimension: Doctor/nurse - user relationship			
Doctor - user relationship			
I trust in the professional capacity of my family doctor	89,2	5,3	5,5
I believe that my family doctor is interested in me	83,9	6,7	9,4
I feel free to question my family doctor about my doubts and/or health problems	89,2	5,0	5,8
My family doctor understands what I say about my health	90,1	4,7	5,2
The information provided to me by my family doctor is easy to understand	91,8	3,8	4,4
The information I receive from my family doctor is sufficient	82,5	8,8	8,7
I recommend my family doctor to my friends and/or family	81,0	11,4	7,6
My family doctor explains the medical procedures and exams necessary for my situation of health/illness	84,8	7,6	7,6
My family doctor involves me in decisions about my situation of health/illness	78,7	12,3	9,0
My family doctor listens to what I have to say about my situation of health/illness	91,5	3,2	5,3
My family doctor knows my clinical/health history	90,4	4,4	5,2
My family doctor takes the best decisions about my treatment	79,5	5,6	14,9
My family doctor is usually concerned about me	80,4	7,3	12,3
Nurse - user relationship			
I trust in the professional capacity of my nurse	69,3	2,3	28,4
I believe that my nurse is interested in me	64,3	3,5	32,2
I feel free to question my nurse about my doubts and/or health problems	67,3	4,1	28,6
My nurse understands what I say about my health	67,8	3,5	28,7
The information provided to me by my nurse is easy to understand	68,1	3,2	28,7
The information I receive from my nurse is sufficient	62,9	4,4	32,7
I recommend my nurse to my friends and/or family	64,9	4,1	31,0
My nurse explains the medical procedures and exams necessary for my situation of health/illness	58,8	5,8	35,4
My nurse involves me in decisions about my situation of health/illness	53,5	10,5	36,0
My nurse listens to what I have to say about my situation of health/illness	60,5	4,7	34,8
My nurse is familiar with my clinical/health history	54,7	9,4	35,9
My nurse takes the best decisions about my treatment	51,8	6,1	42,1
My nurse is usually concerned about me	57,0	6,4	36,6
Dimension: Specialist-user relationship			
I trust in the skills of the specialists who attend to me	2,9	5,9	
I believe that the specialists are interested in me	7,0	13,8	
I feel free to ask questions to the specialists	5,3	6,7	
The specialists understand what I say about my health	2,0	8,2	
The information I receive from the specialists is easy to understand	5,6	8,1	
The information provided to me by the specialists is sufficient	9,6	14,7	
I would recommend my specialists to my friends and/or family	4,4	15,2	

Source: Questionnaire data, 2014.

the family doctor - user relationship ($p = 0.023$) and the nurse-user relationship ($p = 0.002$) and the presence or absence of chronic illnesses, and users without chronic illness viewed relational continuity most positively. Also observed were statistically significant differences between the nurse-user relationship and age ($p = 0.015$) and academic qualifications ($p = 0.001$), wherein younger users and holders of greater academic qualifications where those who contributed the most to relational continuity.

The analysis of data relating to *continuity of information* reveals, with regard to the transfer of clinical information, that the majority of users believe that the specialists have prior knowledge of their clinical history and do not require them to provide the information that the family doctor provided them, as can be seen in Table 2.

In the contrary sense, it is also observed that the majority of the survey respondents mention that when they consult their family doctor, they do not need to provide him or her with information that the specialists provided them and that after being attended to by the specialists, their family doctor refers to that consultation with them.

Using the *One-Way ANOVA* test, it was observed that there are statistically significant differences between *information continuity* and academic qualifications ($p = 0.040$), as the survey respondents with the highest academic qualifications were those who viewed information continuity most positively.

In terms of *management continuity*, some values below 50% were seen in the two dimensions analysed. In the first dimension - coherence/consistency of care - the variables with the lowest values point towards communication between the family doctor and the specialists (negative sense)

and towards non-repetition of exams (positive sense in terms of management of resources). Relating to the values presented by the remaining variables of this dimension, the perception of users is on the whole positive on the coherence and consistency of care received, as can be seen in Table 3.

Accessibility between different levels presents the lowest values of the different dimensions analysed. Half of the users indicate that when specialists direct them to family doctors, it is they themselves (users) who have to deal with all the paperwork for obtaining a consultation at the CS. The values obtained in the different variables of this dimension (below 50%) reveal that accessibility between the different levels of care is viewed negatively by the users.

Using the *One-Way ANOVA* test, it was observed that, concerning *management continuity*, in the coherence/consistency dimension of care, there were statistically significant differences with regard to age ($p = 0.005$) and whether or not the user was suffering from a chronic illness ($p = 0.044$). The oldest survey respondents and those without chronic illness had a positive opinion about the coherence/consistency of care.

In the dimension of accessibility between different levels, it is observed that there are statistically significant differences with age ($p = 0.005$), academic qualifications ($p = 0.007$) and whether or not the user was suffering from chronic illness ($p = 0.014$). Similarly, the oldest survey respondents, with the most academic qualifications and without chronic illness had the most impact in the favourable assessment of accessibility between the different levels.

The analysis of data on *longitudinal continuity* revealed the user's follow-up over time with the observation that, in the previous 12 months,

Table 2. Perception of users with regard to continuity of information.

Dimension: Transfer of clinical information	Yes %	No %	NR %
Dimensão: Transferência de informação clínica			
The specialists attending to me are familiar with my clinical/health history	69,9	18,1	12,0
After going to the specialists, my family doctor refers to that consultation with me	67,8	21,1	11,1
When I consult my family doctor, I do not need to provide him or her information that the specialists gave me	61,1	27,8	11,1
When I consult the specialists, I do not need to provide him or her information that my family doctor gave me	61,4	28,7	9,9

Source: Questionnaire data, 2014.

Tabela 3. Percepção dos utentes relativamente à continuidade da gestão.

Management continuity	Yes %	No %	NR %
Dimension: Coherence/consistency of care			
My family doctor is generally in agreement with the specialists	68,4	8,8	22,8
My family doctor and my specialists communicate with each other about my clinical/health situation	33,3	39,2	27,5
The specialists are generally in agreement with the instructions of my family doctor	54,4	15,5	30,1
The specialists do not repeat exams that I have already performed with my family doctor	43,0	38,9	18,1
The specialists send me to my family doctor for follow-up consultations	63,7	21,6	14,7
The specialists provide me with the first prescription of the treatment prescribed for me	71,6	12,0	16,4
I feel that the attention I receive from my family doctor and the specialists is coordinated	61,4	18,1	20,5
Dimension: Accessibility between different levels			
Visits to the specialists are scheduled from the Health Centre	45,0	45,0	10,0
As long as my family doctor refers me to the specialists, I wait less for speciality consultations	38,6	36,5	24,9
When the specialists refer me to my family doctor, I have to deal with all the paperwork for obtaining a consultation at the Health Centre.	50,0	31,3	18,7
As long as the specialists refer me to my family doctor, I wait less for the consultation	35,4	40,4	24,2

Source: Questionnaire data, 2014.

the majority spoke up to 3 times with the family doctor about their clinical/health situation and performed supplementary diagnostic exams up to 2 times. The majority of users approached their family doctor up to 3 times for a consultation, in the same time period.

In relation to follow-up by the nurse, in the previous 12 months, a high percentage of no responses was noted, varying between 41% and 47%. Only 18.1% mentioned that they had already spoken 4 or more times with the nurse about their clinical/health situation. On the other hand, 21.9% approached the nurse only once in order to consult him or her.

The data relating to *flexible continuity* express the capacity for response in the face of users' needs over time, by different professionals. In terms of the doctor's capacity for response, the majority of users mention that when they need to be urgently attended, they take a maximum of 3 days to be able to speak with the family doctor. It is noted, however, that 44.2% manage this in less than 1 day. The majority of users feel that it is easy to manage to speak with the family doctor about their situation of health/illness when they need to.

While analysing the nurse's capacity for response, the results obtained reveal that 44.7%

of users wait for less than 1 day to speak to this professional, in an emergency situation. However, 8.8% may wait 1 to 7 days to manage to speak with a nurse, in an emergency situation. Although the majority of users (59.4%) mention that it is easy to manage to speak to the nurse about their clinical/health situation, this percentage is clearly lower than the one given for the same situation with the doctor.

Discussion

In order to better frame the results obtained, it becomes necessary to refer to the reform of CSP in Portugal, which took place in 2005, due to the relationship this could have with the degree of satisfaction and with accessibility, variables that are inseparable from the evaluation of continuity of care from the perspective of users. The top-priority objectives of this reform were: to create conditions for the provision of more and better healthcare and the increase in accessibility and proximity to citizens²⁶. The results of the analysis performed, by the Consulting Group for the Reform of CSP (GCRCS), present the results of the reform as positive, mentioning an

increase in access and satisfaction, of professionals as well as users^{27,28}. The USFs were mentioned as their most visible face, due to the possibility of extension of public coverage.

Continuity of care is related to the increase in user satisfaction, and there is evidence of its association with the aspects of use of healthcare. Several studies have shown that accessibility to healthcare in Portugal has improved significantly in recent years, together with user satisfaction in relation to care received^{29,30}.

With regard to the relations with the quality of technical assistance and with health results, the studies on continuity are not consensual³¹.

In terms of *relational continuity*, users positively value the relationship with the professionals attending to them - medical, nursing and specialist. It is felt that health professionals are interested in and concerned about them, and they feel free to clear their doubts and feel that they have been heard.

Statistically significant differences are observed between the doctor-user and nurse-user relationship, and the presence or absence of chronic illness. Users that do not have chronic illnesses are the ones who maintained a greater relationship with these professionals, which is not in agreement with other studies³² which mention that for users with chronic illness, relational continuity is most important.

The survey respondents show clear trust in the health professionals who attend to them. The lowest values, which are still rather high, concern the involvement of users in decisions on their situation of health/illness and relating to decision making on the best treatment. The principle of autonomy is also seen to be respected, this being, in the doctor-user relationship, extremely relevant, to the extent that medical procedures are discussed and only carried out if the user is in fact capable and aware to accept such procedures and attitudes.

In the area of relational continuity, what also stands out is the low values obtained in the nurse-user relationship. If the organisation of the CS's by a family doctor ensures continuity in the doctor/user relationship, which reflects the immediate recognition by the user, this does not take place with the nurse. The fact of the absence of a model nursing professional who ensures care to individuals and families through a relationship maintained over time, seems to make it harder to win over trust and simultaneously justifies the values obtained. Even so, users recognise that nurses are concerned with them and that they are

familiar with their clinical and health history, establishing a relationship of trust to question and clarify doubts about their problems.

This fact leads to reflection on the importance of implementation of the figure of the Family Nurse in the current context of CSP. As with the family doctor, what is desired is that this person be *the model qualified support professional who, in functional complementarity and from a perspective of intervention in a network, responds to family needs in exercising family functions*³³. In fact, the nurse, particularly in CSP, plays a leading role, *to the extent that the thrust and provision of services are moving increasingly from the hospital to the home, from curative to preventive, from institutions to communities, and nurses are increasingly in the centre of the vortex of healthcare – the glue that brings continuity to care*³⁴.

Continuity of care inevitably entails working in partnership, with each person taking on responsibility for his or her health and everyone taking on responsibility for the health each one, wherein *communication of information* between all involved is the common thread in this relationship.

In this study, this relationship is clearly visible. The channels of communication between the different professionals are seen as open, as the users mention that the specialists have prior knowledge of their clinical history, while the result of consultations with the specialists also becomes known to the family doctor, without the user needing to be the transmitter of this information. This fact is borne out in other studies³⁵, which mention that continuity of care must have open and effective communication between the two areas of activity as an essential condition. The value of continuity for users appears to be associated with a sense of being cared for, of being understood and the trust placed in professionals²⁴. This aspect becomes more relevant when it relates to the transition of the user from the hospital environment to the home. The way in which the entire process develops influences the continuity or lack of it in the care provided. The planning of the discharge is a determining factor in the patient's transition, from the hospital to the home, and guarantees continuity of care³⁶. It has become increasingly clear that, although continuity is a (high) priority for many users, its importance varies for different groups of users, with different types of health problems²⁴.

In turn, the CS, due to proximity with people, must be the promoter, evaluator, manager and coordinator of this care coordination network

system³⁷, which is once again seen in the results of our study on establishing open communication between specialists and the family doctor in care of the user and the perception of users about the coordination between them, on considering that the attention received from the family doctor and the specialist is coordinated.

The statistically significant differences between *information continuity* and academic qualifications of the survey respondents, reveal that those possessing higher academic qualifications have greater perception in terms of communication of information. Higher literacy levels are associated with greater literacy levels in health³⁸.

In relation to *management continuity* between the family doctor and the specialist, it is observed that the majority of users mentioned having to repeat the exams that had already been performed with their family doctor. This aspect may reveal a possible element of discontinuity, potentially problematic for users with complex pathologies and with co-morbidities in which a multidisciplinary intervention is required³⁹ leading to an unnecessary duplication of exams, medical errors and inconsistent treatments.

Still in management continuity, in the dimension of accessibility between different levels of care, it is observed that there are statistically significant differences with age and academic qualifications. The elderly and those with higher academic qualifications are those that perceive this dimension of continuity most positively.

In the context of the *therapeutic relationship over time*, the follow up performed on the user by the doctor, or by the nurse, imply that it does not take place only at times of scheduled consultation, but that there is a capacity for response of professionals to sporadic requests. This accessibility to services, as an integrating part of flexible continuity, is also a dimension of the quality of care, visible in the results presented which entail a reduced wait time, for medical consultations or nursing.

Conclusion

Continuity of care covers a set of dimensions conducive to the improvement of healthcare provided to the public and their subsequent satisfaction with the care received.

In this study, we identified elements of continuity at the level of different dimensions of the continuity of care – relational, information, management, longitudinal and flexible continuity.

Based on the perception of users, it is concluded that there are lacunas at the level of relational continuity, namely in terms of the involvement of users in decisions that relate to their health, a requirement given in the Declaration of Alma-Ata (1978) which called for care to be placed within the reach of all individuals and families of the community, by means of their full participation.

Also in terms of relational continuity, the fact that the users express satisfaction with the care received is noteworthy, as revealed when they recommend their family doctor and nurse to family members and friends.

The continuity of management, in spite of elements of discontinuity that were found, with respect to the coherence/consistency of care, the results reveal that family doctors are more often in agreement with the specialists than the other way round. Also to be highlighted are the lacunas indicated at the level of transmission of information between the family doctor and the specialists about the user's clinical/health situation and the repetition of exams pointed out when they consult with the specialist. Also, accessibility between the different levels is not facilitated, namely with respect to the waiting time for speciality consultations, or those with the family doctor.

The improvement of accessibility, efficiency, quality and continuity of care and, subsequently, the satisfaction of professionals as well as users, was one of the aims of the reform of Primary Health Care. The health centres represent the first access of users to healthcare, assuming the responsibility for health promoting and disease prevention activities, provision of care during illness and promotion of continuity of care.

Another reflection that is arrived at is about the importance of implementing the figure of the Family Nurse, as a fundamental resource for the promotion of individual, family and collective health and due to his or her leading role as a manager of nursing care, strengthening individual health in the family context. This will facilitate the connection between the family, other professionals and community resources, encouraging greater equity in access to healthcare, continuity of care and greater proximity to citizens.

In spite of wariness that exists about perceptions of users in evaluating continuity of care, it is felt that listening to the perceptions of users is giving a voice to (encouraging) citizens in health and social issues.

Collaborations

FRP Mendes, MLGP Gemitto, EC Caldeira, IC Serra and MV Casas-Novas participated equally in all the stages of preparation of the article.

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