STARFIELD SUMMIT

...where primary care research inspires policy and practice

4Cs of Primary Care: Continuity

Why this is important (brief description):

Continuity of care was labeled by Barbara Starfield & the Institute of Medicine as a defining characteristic of primary care, one that Barbara Starfield and others demonstrated as essential to primary care's positive impact on health equity, cost reduction, and improved quality of care. Francis Peabody famously described continuity as an implicit contract between physician and patient in which the physician assumes ongoing responsibility for the patient, and frames the personal nature of medical care, in contrast to the dehumanizing nature of disjointed care. Its salutary effects on health are borne of the idea that knowledge, trust, and respect develop between the patient and provider over time, allowing for better interaction and communication. These effects are well supported by a long literature on the host of benefits associated with clinician to patient continuity. Despite this evidence, Americans' ability to identify a usual source of care has been declining for years, and in an age of increasing fragmentation, shiftwork, and care-seeking through technology, patient to physician continuity is evolving and possibly declining. Residency educators pondering the evolution of Family Medicine training over the next two decades will have to decide if and how to use educational policy levers to retain continuity in training.

What We Think We Know (Bulleted evidence + Seminal references):

- Continuity of primary care has been shown to have positive impact on a host of patient outcomes, including satisfaction of care, lowering undesirable utilization of care and costs of care, and disease outcomes[i,ii,iii]
- Continuity of primary care is thought to impact patient health through relational, longitudinal and administrative components
- Americans' ability to identify an individual usual source of care (USC) has been declining for years[iv] while identification with an institution or "no USC" has risen, and such variation influences costs of care[v]
- Continuity is measurable not only at the patient level, but also for clinicians and practices, using administrative and claims data
- There is a strong association between higher levels of physician-level continuity, a core tenet of primary care, and lower total health care costs and hospitalizations[vi]
- Residencies can be redesigned to positively impact continuity relationships, but more research is needed to understand how changes in continuity affect resident and patient satisfaction, patient outcomes, and resident career choice. A lack of empanelment of resident patients makes measuring and positively impact residency continuity challenging[vii]

Questions for Group Consideration at the Starfield Summit:

- How are technology, patient preferences, primary care transformation, and changes to payment/delivery systems reshaping trends in continuity of care?
- Should residency requirements include a standard for continuity rate among residents?
    - If so, what steps can residencies take to optimize continuity of care in training?
    - And what measures of effective, continuous care can residency educators utilize to evaluate their trainees?
    - How can the RRC balance the need to implement ethical workplace practices (e.g. shift-work) for trainees while also effectively training them on continuity of care?
    - How can continuity measurement impact resident behaviors during training and in downstream practice?
- What do consolidation and physician employment mean for continuity in training & practice?
- How will team-based training shape continuity of care in the future & what does this mean for residency redesign?
- In the COVID era, with health information technology facilitating asynchronous and distanced communication between physician and patient, is continuity of care becoming more or less robust as a result? Should RRC standards include telehealth continuity visits?
- What are optimal Family Medicine office systems for supporting continuity? And how important is extending our residents' continuity to the hospital for inpatient care & deliveries?
- How will the roles of current care providers change as technology, pt preferences, primary care transformation, and payment and delivery systems undergo changes?
- What are the most effective training approaches & curricula required to achieve greater continuity in primary care practice?
- How does practice or team-based continuity differ from individual continuity in its measurable outcomes at the patient level?

References:

[i] Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. Ann Fam Med. 2004;2(5):445-451

[ii] Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Ann Fam Med. 2005;3(2):159-166

[iii] McWhinney IR. Continuity of care in family practice. Part 2: implications of continuity. J Fam Pract. 1975;2(5):373-374

[iv] Liaw, W., Jetty, A., Petterson, S., Bazemore, A. and Green, L. (2018), Trends in the Types of Usual Sources of Care: A Shift from People to Places or Nothing at All. Health Serv Res, 53: 2346-2367.

[v] Phillips RL, Dodoo MS, Green LA, et al. Usual source of care: an important source of variation in health care spending. *Health Aff (Millwood)*. 2009;28(2):567-577. doi:10.1377/hlthaff.28.2.567

[vi] Bazemore A, et al. Higher primary care physician continuity is associated with lower costs and hospitalizations. Ann Fam Med. 2018; **16**(6): 490-491

[vii] Walker J, Payne B, Clemans-Taylor BL, Snyder ED. Continuity of Care in Resident Outpatient Clinics: A Scoping Review of the Literature. *J Grad Med Educ*. 2018;10(1):16-25. doi:10.4300/JGME-D-17-00256.1

SEE SUPPLEMENTAL REFERENCES ON EXPERIMENTS DESIGNED TO INFLUENCE CONTINUITY IN RESIDENCY IN "APPENDIX – CONTINUITY"