Continuity of Care as a Quality Metric

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The *Annals of Family Medicine* encourages readers to develop a learning community to improve health and health care through enhanced primary care. With the *Annals* Journal Club, we encourage diverse participants—particularly among students, trainees, residents, and interns—to think critically about and discuss important issues affecting primary care, and even consider how their discussions might inform their practice.[1]

HOW IT WORKS

The *Annals* provides discussion tips and questions related to one original research article in each issue. We welcome you to post a summary of your conversation to our eLetters section, a forum for readers to share their responses to *Annals* articles. Further information and links to previous Annals Journal Club features can be found on our website.

CURRENT SELECTION

Dai MD, Pavletic D, Shuemaker JC, et al. Measuring the value functions of primary care: physician-level continuity of care quality measure. Ann Fam Med. 2022;20(6):535-540.

Discussion Tips

Dr Barbara Starfield defined the 4 functions of primary care as first contact, continuity, comprehensiveness, and coordination. The authors of this study used a database that included claims from large commercial insurance and Medicare Advantage health plans to test the reliability and validity of a clinical quality measure based on 1 of these functions, continuity of care (CoC). They then explored whether there was an association between physicians having a greater percentage of patients with CoC >0.7 and a lower percentage of patients with 1 or more emergency department visits during the 12-month study period.

Discussion Questions

- What questions are asked by this study and why do they matter?
- How do clinical quality measures influence the behavior of health care systems, in general, and physicians, in particular?
- How does the way the physician continuity of care measure is operationalized represent how primary care is currently practiced? How could the exclusion of nurse practitioner and physician assistant visits influence results of the measure?
- Does the continuity of care equation meet an acceptable level of face validity for you?
- Why is it important that the continuity of care measure is reliable?
- Do you think that the sample characteristics are representative of the average family practice?
- What is adjustment, and how do the authors use adjustment in the linear regression? Is there potential for confounding based on individual patient characteristics or health system design?
- Do you agree with the authors' decision to use a continuity of care of greater than 0.7 as the threshold for better patient outcomes? What are downsides of dichotomizing continuous variables?
- Explain the main results of the adjusted model described in Table 3 in plain language using pediatrics as the reference specialty. What does it mean that the coefficient for the continuity of care is largely the same for both the unadjusted and adjusted models?
- Are there ways that you might strengthen the study design to better determine causality between primary care physician continuity and emergency department utilization?
- At your workplace what barriers exist to maximizing continuity of care at both the clinic and patient levels? How could these barriers influence the association that the authors found between continuity of care and emergency department visits?
- What are potential positive and negative outcomes from using this measure of continuity of care as a quality metric?

REFERENCES

1. Stange KC, Miller WL, McLellan LA, et al. *Annals* Journal Club: it's time to get RADICAL. *Ann Fam Med.* 2006;4(3):196-197. https://AnnFamMed.org/cgi/content/full/4/3/196