Convenience or Continuity: When Are Patients Willing to Wait to See Their Own Doctor?

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ABSTRACT

PURPOSE Much of the literature on team-based primary care has focused on physician productivity, workload, and burnout. Less is known about how team-based care influences patient satisfaction and perceptions of the trade-off between continuity and access. This study assessed the preferences of family medicine patients for seeing their primary care physician (PCP) vs other team clinicians based on visit type and wait time.

METHODS Our cross-sectional online survey asked patients about their primary care clinics, PCP, portal use, self-reported health, and demographics. For multivariate analysis, we used weighted logistic regression analysis with survey data to calculate maximum likelihood estimates and converted these to odds ratios. We controlled for age and self-reported health as continuous variables and for demographics as categorical variables.

RESULTS We surveyed 4,795 adult patients and received responses from 2,516 (52.5%). More than one-half of patients preferred to see only their PCP for an annual checkup (52.6%), follow-up of a chronic condition (54.6%), or follow-up for a mental health condition (56.8%). Similarly, the majority of patients preferred to wait 3 to 4 weeks to see their PCP for issues possibly requiring a sensitive examination (68.2%), a new mental health concern (58.9%), or a new concern about a chronic condition (61.1%).

CONCLUSIONS Our findings show that patients value having a PCP and maintaining continuity with their PCP. They also provide insight on when patients would prefer to wait to see their own PCP vs being seen more quickly by another clinician. As health care delivery and scheduling continue to evolve, these findings provide guidance for leaders in primary care.

Ann Fam Med 2025;23:151-157. https://doi.org/10.1370/afm.240299

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VISUAL ABSTRACT

INTRODUCTION

Primary care delivery and use have changed considerably over the past 2 decades, including the expansion of team-based primary care[1,2] and the emergence of urgent care centers.[3] Both can be seen as efforts to improve patient access. Although urgent care centers offer convenient access, they often lack continuity. Team-based care, on the other hand, includes a variety of clinicians—physicians, physician assistants, nurse practitioners, nurses, social workers, behavioral health specialists, pharmacists, medical assistants, and others—working together to care for a patient population.

Many studies have evaluated health and productivity outcomes associated with team-based care[4-7]; however, patient perceptions of team-based care, including how patients weigh trade-offs between maintaining continuity with their primary care physician (PCP) vs obtaining more expedient care from other clinicians, are not as well understood. One study found that patients who preferred seeing their PCP vs other clinicians, including advanced practice providers, valued physician qualifications and trust, whereas those who preferred seeing advanced practice providers placed greater value on convenience and bedside manner.[8] A review article that attempted to understand and categorize the attributes of primary care most important to patients found that the top 3 were their specific health care professional, the process of shared decision making, and (shortness of) wait time.[9] Patients have also clarified that they prefer to wait to see their PCP for routine checkups and medical problems with uncertainty as opposed to minor, "low-impact" symptoms for which they are content to see the next available clinician.[10]

Studies have looked specifically at factors that influence patients' relationships with their PCP and the value they place on continuity of care. One study evaluated

AJC *Annals Journal* Club selection

Conflicts of interest: authors report none.

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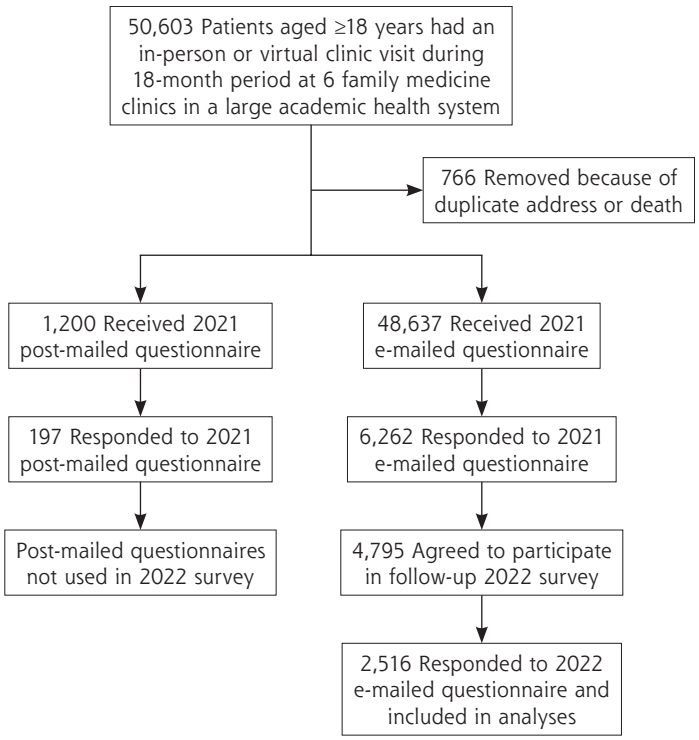
the impact of continuity with one's PCP on patient experience and found that patients with worse self-rated health, and those who had recently established care with their PCP, were more strongly influenced by visit continuity.[11] Another study found that extremes of age (age younger than 6 years and older than 40 years), female sex, lower educational attainment, Medicare and Medicaid insurance, number of visits to the practice, and worse self-reported health status were all associated with higher value placed on continuity of care.[12] Shorter wait times to be seen, having a designated PCP, better perceived choice of selecting a PCP, and having a longer duration of relationship with the PCP all have been associated with higher ratings of the patient-PCP relationship.[13]

Although research has demonstrated the importance of the patient-physician relationship on the primary care experience,[10-12] less is known about the circumstances in which patients are willing to trade between convenience and continuity. Moreover, evaluations of how patient-specific factors correlate with preferring expedient care vs maintaining continuity with one's PCP are not well understood and have not been recently evaluated in the context of the rapidly changing primary care landscape. Better understanding of these preferences can help direct future innovations in primary care delivery and provide guidance on scheduling and staffing decisions in a team-based primary care model.

Figure 1. The 2021-2022 Patient Well-Being Survey: Patient Selection and Survey Distribution



METHODS

Patient Selection and Questionnaire Distribution

We analyzed data from the ongoing Patient Well-Being Survey, a cross-sectional online survey of primary care patients in Michigan. In 2021, we used our electronic health record to identify all 50,603 patients aged 18 years or older who attended an in-person or virtual clinic visit within the past 18 months from 6 family medicine clinics in a large academic health system. We sent online questionnaires to patients with e-mail addresses and paper questionnaires to those without. The questionnaires were offered in English, Spanish, and Japanese.

Regarding the translation process, within the department of family medicine faculty and staff, 2 native-speaking Japanese staff were identified to help with the translation and back-translation of the questionnaire (Supplemental Appendix 1). One Japanese-speaking staff member translated the questionnaire from English to Japanese, and then another Japanese-speaking staff member translated it back from Japanese to English to look for any errors or inconsistencies. The 2 staff members then reviewed the translated questionnaires together item by item and agreed on the best translation based on any inconsistencies noted. For the Spanish translation of the questionnaire, we similarly identified 2 translators. The survey was translated from English to Spanish and reviewed to ensure quality. Once the review was completed, a project manager finalized the format of the translation and gave it back to the reviewer to check the translation once more before finalizing and certifying the translation.

A total of 6,459 patients returned the 2021 questionnaire (12.8% response rate), of whom 4,795 agreed to receive annual follow-up questionnaires as a part of a longitudinal cohort (Figure 1). In 2022, we discontinued use of paper questionnaires because of their cost and low return rate. The analyses presented here are based on the responses to the 2022 survey.

Survey Content

Our 2022 survey included questions about patients' primary care clinics and clinicians, their PCP, and portal use, as well as open-ended questions about their satisfaction with care. It also included questions from the Person-Centered Primary Care Measure,[14] which measures aspects of high-value primary care, and the What Matters Index (WMI),[15] a brief quality of life measure that reliably predicts use of emergency department and hospital services by patients with chronic illness. We omitted 1 question ("Do you think any of your pills are making you sick?") for brevity. For the WMI, each item is scored 0 or 1 and then summed, with higher total scores predicting greater risk for emergency department use and hospitalization. Patients with higher WMI scores may benefit the most from access to high-quality primary care. Finally, we collected demographic data on age, education, race, ethnicity, gender, and insurance type.

In 2022, we asked respondents to consider 5 types of visits: the annual health maintenance examination/checkup, a new symptom visit, a visit for an urgent concern for which they needed to be seen within 24 hours, a follow-up visit for a chronic condition, and a follow-up visit for a mental health condition. For each visit type, patients were asked to indicate their preference by choosing among 3 options: see only their PCP, prefer their PCP but willing to see another clinician, or see the first available clinician. For analysis, we made the outcomes dichotomous: see only their PCP vs see another clinician. To assess the importance of seeing their PCP vs having to wait, we offered 5 hypothetical medical concerns (sore throat, concern requiring a sensitive examination, bodily pain, new mental health concern, or a new concern about a chronic condition) and asked patients to choose between seeing their PCP in 3 to 4 weeks or seeing the next available clinician in 24 to 48 hours.

Table 1. Patient Characteristics

Characteristic[a]	Unweighted No. (%) (N = 2,319)	Weighted No. (%) (N = 2,320)
Language		
English	2,299 (99.1)	2,279 (98.2)
Japanese	11 (0.5)	20 (0.9)
Spanish	9 (0.4)	21 (0.9)
Gender		
Female	1,531 (66.0)	1,340 (57.8)
Male	766 (33.0)	968 (41.7)
Other	22 (0.9)	12 (0.5)
Race		
Asian	78 (3.4)	156 (6.7)
Black/African American	41 (1.8)	270 (11.6)
White/Caucasian	2,112 (91.1)	1,748 (75.3)
Other[b]	88 (3.8)	147 (6.3)
Ethnicity		
Hispanic	48 (2.1)	70 (3.0)
Non-Hispanic	2,266 (97.7)	2,247 (96.9)
Missing	5 (0.2)	3 (0.1)
Education		
< 8th grade or HS/GED	83 (3.6)	67 (2.9)
Some college/associate's degree	430 (18.5)	396 (17.1)
Bachelor's degree or higher	1,804 (77.8)	1,856 (80.0)
Missing	2 (0.1)	2 (0.1)
Insurance type		
Public[c]	973 (42.0)	649 (28.0)
Private	1,340 (57.8)	1,665 (71.8)
Missing	6 (0.3)	6 (0.2)
Site		
Resident	556 (24.0)	526 (22.7)
Nonresident	1,736 (74.9)	1,775 (76.5)
Missing	27 (1.2)	20 (0.8)

GED = General Educational Development Test; HS = high school.

[a] Mean (SD) age was 58.8 (14.3) years in the unweighted sample and 52.0 (15.3) years in the weighted sample. Mean (SD) What Matters Index score was 1.1 (1.1) in the unweighted sample and 1.0 (1.1) in the weighted sample; possible scores range from 0 to 4, with higher scores indicating poorer health and predicting greater risk for hospitalization and emergency department use by patients with chronic illness.

[b] American Indian, Alaskan Native, Native Hawaiian, Pacific Islander, and write-in answers.

[c] Medicare and Medicaid.

Data Analysis

To better align our survey results with our clinic demographics, we weighted by age, gender, and race based on the total number of patients at the 6 sites who matched study inclusion criteria. Weights (Supplemental Appendix 2) were calculated by dividing the population proportion by the survey proportion for each of 18 subgroups based on age categories (18-40 years, 41-60 years, and ≥61 years), gender (male, female, or other), and race (Black or African American, White or Caucasian, or other). Demographics, PCP access, clinic satisfaction, and portal use were summarized with descriptive statistics and weighted as above.

We tallied responses for the full group and for each demographic subgroup. Regarding race, we used self-reported options for race reporting that are offered in our health record, including a write-in option for "other." For the sake of analysis, however, we used "other" as an extended race category that included American Indian, Alaskan Native, Native Hawaiian, Pacific Islander, and write-in answers. Two of the clinics are resident sites, and the majority of physicians at these sites are resident physicians: 21 out of 37 physicians at one site and 18 out of 34 physicians at the other site. Recognizing that patient experiences differ at resident sites, patient responses from resident sites were compared against those from nonresident sites in the analysis. Differences among demographic subgroups were assessed using the χ^2 test or Fisher exact test, using a significance level of $P < .05$.

For multivariate analysis, we conducted weighted logistic regression analysis with survey data using SAS version 9.4 (SAS Institute Inc) to calculate the maximum likelihood estimates and converted these to odds ratios. We controlled for age and self-reported health (based on WMI score) as continuous variables and the other demographics (race, ethnicity, gender, insurance, clinic site, and education) as categorical variables.

RESULTS

Of 4,795 patients sent questionnaires in 2022, a total of 2,516 (52.5%) returned them. We excluded those with less than 95% completion (127 questionnaires), those reporting insurance type as uninsured (4 questionnaires), and those missing variables used for weighting (66 questionnaires). This left 2,319 questionnaires (48% of all sent) for analysis. Less than 2% of data were missing for all demographic variables. Table 1 shows the unweighted and weighted demographics for the study population. Subsequent analyses show weighted data only.

Weighting of data resulted in 2,320 patients with an average age of 52 years (Table 1). Overall, 57.8% were female and 75.3% were White. Some 80.0% of patients had a bachelor's degree or higher; 71.8% had private insurance, whereas 28.0% had public insurance (Medicare or Medicaid). The weighted number of participants is 1 more than the actual number of survey respondents because of rounding.

Views on PCPs

Overall, 94.1% of the 2,320 patients reported having a PCP (data not shown). The large majority, 71.4%, said it was extremely important to have a personal PCP, and 24.3% said it was somewhat important. Patient perceptions about the quality of PCP relationships varied substantially, however. Just 26.5% reported having a very strong relationship, while 32.6% reported a relationship that was somewhat strong, 31.1% somewhat limited, and 10.0% very limited.

When Do Patients Want to See Only Their PCP?

Patients had strong opinions about when they would agree to see a clinician other than their own PCP (Figure 2). Approximately one-half reported wanting to see only their PCP for an annual checkup (52.6%), follow-up of a chronic condition (54.6%), or follow-up for a mental health condition (56.8%). But for an urgent concern, just 7.2% would wait, and for new symptoms, only 17.1% would wait to see their PCP.

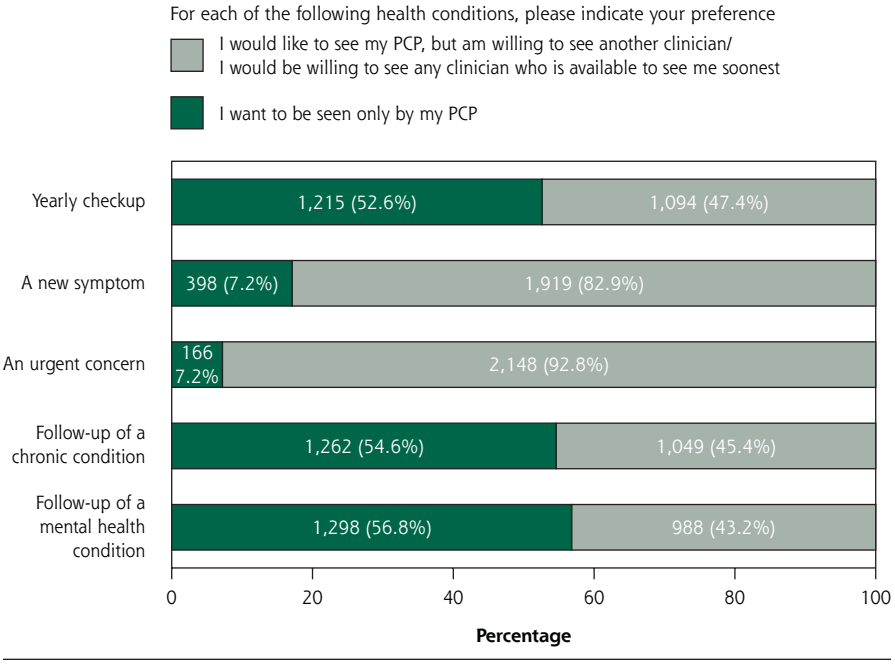
For each scenario, multivariate analyses were used including age, gender, ethnicity, education, race, insurance, and WMI score, with higher score used as a predictor for higher health care use (Table 2). In these analyses, patients were more likely to prefer to see only their PCP for an annual checkup if they were older (odds ratio [OR] per year = 1.03; CI, 1.01-1.04; P <.001) or female (OR = 1.68; CI, 1.29-2.20; P <.001). For follow-up of a chronic health condition, patients with higher WMI scores had a higher likelihood of wanting to see only their PCP (OR = 1.15; CI, 1.03-1.30; P = .02) (Table 3). For a new symptom, patients who had less education, specifically, a high school education/General Educational Development Test or less (OR = 3.60; CI, 1.99-6.50; P <.001) or some college or an associate's degree (OR = 1.74; CI, 1.15-2.62; P = .008), more commonly wanted to see only their PCP (Supplemental Table 1). For an urgent concern, those with less education had higher odds of wanting to see only their PCP (OR = 3.57; CI, 1.59-8.02; P = .002), whereas those who were female vs male had lower odds (OR = 0.45; CI, 0.26-0.77; P = .004) (Supplemental Table 2). Lastly, although the large majority of patients indicated that they wanted to see only their PCP for follow-up of a mental health problem, there were no significant differences between groups in multivariate analysis for this preference (Supplemental Table 3).

Conditions for Which Patients Would Wait 3 to 4 Weeks to See Their PCP

For various concerns, we asked respondents whether they would rather see their own PCP in 3 to 4 weeks or any available clinician in the next 24 to 48 hours. For issues requiring a sensitive examination, a new mental health concern, or new concern about a chronic condition, the majority reported they would wait 3 to 4 weeks to see their PCP (68.2%, 58.9%, and 61.1%, respectively) (Figure 3). In contrast, just 6.9% would wait to see their PCP for a sore throat and only 33.9% would wait if they had bodily pain.

Our multivariate analyses for each scenario included age, gender, ethnicity, education, race, insurance, and WMI score (Table 4). If the concern required a sensitive examination, females had 44% higher odds compared with males of preferring to wait 3 to 4 weeks to see their PCP (OR = 1.44; CI, 1.09-1.89; P = .009). For a new mental health concern, patients seen at a nonresident site were less likely to want to wait 3 to 4 weeks to see their own PCP (OR = 0.69; CI, 0.48-0.98; P = .04) (Supplemental Table 4). For a new concern about a chronic condition, differences were not significant in multivariate analysis (Supplemental Table 5). For evaluation of a sore throat, patients were more willing to wait if they were Asian (OR = 3.39; CI, 1.58-7.24; P = .002), had less education

Figure 2. Preference for Seeing Only One's PCP vs Willingness to See Other Clinician by Visit Type



PCP = primary care physician.

(OR = 2.45; CI, 1.14-5.27; P = .02), or were seen at a resident site (OR = 1.71; CI, 1.01-2.91; P = .047) (Supplemental Table 6). For bodily pain, patients indicated greater willingness to wait if they identified as other gender vs male gender (OR = 3.35; CI, 1.26-8.91; P = .02) or were Hispanic (OR = 2.15; CI, 1.01-4.57; P = .048) (Supplemental Table 7).

DISCUSSION

Most patients in our study placed strong importance on having a personal PCP and valued continuity of care. Our findings corroborate those from a similar study indicating that patients have stronger preferences for seeing their PCP for their annual checkup or when following up on a chronic health condition, while our results also show that patients have a strong preference to see only their PCP for follow-up of a mental health condition.[10] Still, nearly one-half of patients responded with a willingness to see other clinicians for these types of visits, demonstrating considerable variability.

Certain patient characteristics were associated with a preference to see only one's PCP. Older patients and female patients were more likely to want to see their PCP for an annual checkup, and those with poorer health status were more likely to want to see their PCP for follow-up of chronic health conditions. These patterns are similar to those in past studies highlighting that older age, worse self-reported health status, and female sex were associated with placing higher value on continuity of care.[16]

Our data demonstrate that most patients are willing to wait 3 to 4 weeks to see their own PCP for certain types of visits, underscoring the importance of seeing someone they trust over the convenience of being seen more quickly. Further highlighting the value of physician continuity, a recent study found that high continuity with one's own physician was associated with lower emergency department use for all patients, as well as fewer hospitalizations for the most complex patients.[7] As trends show an increase in the use of urgent care centers in the United States,[3] as well as health systems prioritizing expedient access over continuity, data from our study and others suggest that these shifts do not align with patient preferences for care, or with important health outcomes such as emergency department and hospital use.

Like most studies using surveys, our study has certain limitations. Our survey was conducted at 6 family medicine clinics in a large academic health system, including 2 clinics that serve as sites for family medicine resident training. Patients in these settings may differ in expectations and experiences compared with those who choose to get their care at smaller independent clinics, concierge practices, or direct primary care. Furthermore, our response rate of 52.5% may have resulted in response bias, which limits external generalizability. Bias by age, gender, and race were reduced by weighting responses. The percentage of our patients who had a bachelor's degree or more education (77.8%) is much higher than the annual percentage in the general population per US census data (37.9%),[17] again limiting external generalizability. In 2022, we surveyed only patients with a listed e-mail address, which may have limited input from patients with less

Table 2. Predictors of Preference to See Only One's PCP for Annual Examination

Characteristic	Odds ratio (95% CI)	*P* value
Age, per year	1.03 (1.01-1.04)	< .001
Gender (ref = male)		
Female	1.68 (1.29-2.20)	< .001
Other	2.11 (0.76-5.86)	.15
Ethnicity: Hispanic (ref = non-Hispanic)	1.17 (0.54-2.52)	.70
Education (ref = bachelor's degree or higher)		
< 8th grade or HS/GED	1.16 (0.60-2.22)	.66
Some college/associate's degree	1.05 (0.75-1.47)	.78
Race (ref = White/Caucasian)		
Black/African American	0.79 (0.39-1.59)	.51
Asian	0.86 (0.49-1.54)	.62
Other	0.68 (0.40-1.16)	.16
Insurance: private (ref = public)	1.34 (0.94-1.91)	.11
Site: resident (ref = nonresident)	0.67 (0.49-0.91)	.01
What Matters Index score, per point	1.06 (0.93-1.20)	.36

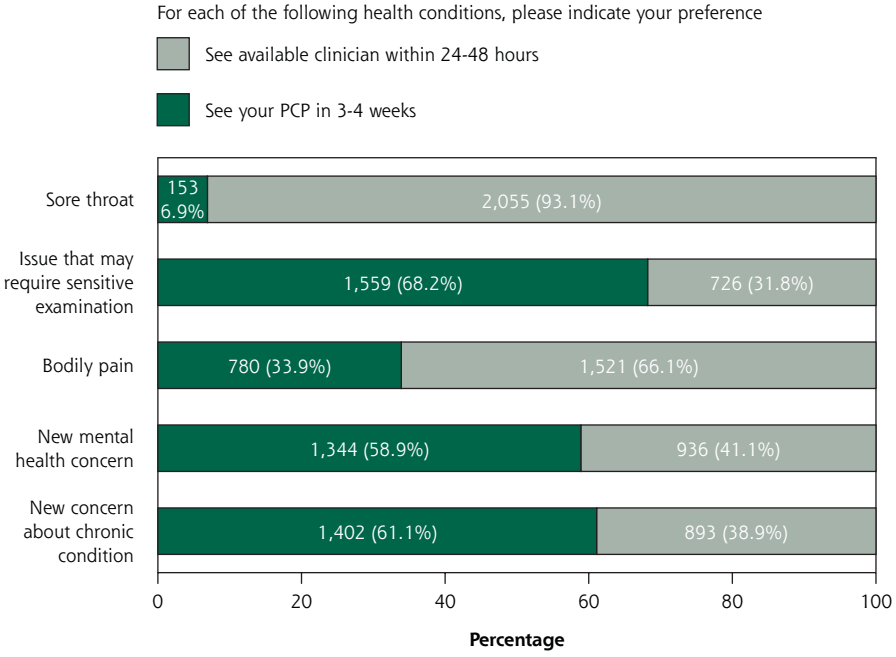
GED = General Educational Development Test; HS = high school; PCP = primary care physician; ref = reference group.

Table 3. Predictors of Preference to See Only One's PCP for Follow-up of a Chronic Condition

Characteristic	Odds ratio (95% CI)	*P* value
Age, per year	1.01 (0.99-1.02)	.37
Gender (ref = male)		
Female	1.08 (0.82-1.43)	.57
Other	0.89 (0.35-2.25)	.80
Ethnicity: Hispanic (ref = non-Hispanic)	0.82 (0.39-1.74)	.61
Education (ref = bachelor's degree or higher)		
< 8th grade or HS/GED	1.02 (0.57-1.83)	.95
Some college/associate's degree	0.86 (0.62-1.19)	.37
Race (ref = White/Caucasian)		
Asian	1.21 (0.68-2.15)	.52
Black/African American	1.81 (0.81-4.00)	.15
Other	0.90 (0.52-1.56)	.70
Insurance: private (ref = public)	1.13 (0.82-1.57)	.45
Site: resident (ref = nonresident)	0.90 (0.63-1.28)	.55
What Matters Index score, per point	1.15 (1.03-1.30)	.02

GED = General Educational Development Test; HS = high school; PCP = primary care physician; ref = reference group.

Figure 3. Preference for Waiting to See One's PCP vs Seeing Next Available Clinician for Specific Medical Concerns



PCP = primary care physician.

Table 4. Predictors of Preference to Wait 3-4 Weeks to See One's PCP for Issues Requiring a Sensitive Examination

Characteristic	Odds ratio (95% CI)	*P* value
Age, per year	0.99 (0.98-1.00)	.09
Gender (ref = male)		
Female	1.44 (1.09-1.89)	.009
Other	1.72 (0.55-5.42)	.35
Ethnicity: Hispanic (ref = non-Hispanic)	1.50 (0.60-3.76)	.39
Education (ref = bachelor's degree or higher)		
< 8th grade or HS/GED	0.99 (0.53-1.87)	.98
Some college/associate's degree	1.00 (0.70-1.42)	.98
Race (ref = White/Caucasian)		
Asian	0.68 (0.37-1.26)	.22
Black/African American	1.47 (0.65-3.33)	.35
Other	0.51 (0.29-0.89)	.02
Insurance: private (ref = public)	1.16 (0.83-1.63)	.39
Site: resident (ref = nonresident)	0.89 (0.63-1.25)	.51
What Matters Index score, per point	1.09 (0.97-1.23)	.14

GED = General Educational Development Test; HS = high school; PCP = primary care physician; ref = reference group.

technology access, who may disproportionately be older and have lower socioeconomic status.[18]

Although parts of our survey included validated questionnaires, the questions about PCP access and portal use were based on qualitative comments by patients in the prior year as no validated surveys on these topics were available. We omitted 1 question from each validated instrument, but as these responses were analyzed as continuous variables, those omissions are unlikely to have substantially affected results. Our responses come from the subset of patients who initially responded in 2021 and agreed to participate in a follow-up survey, so are more likely to represent individuals in stable life situations allowing them to use the same clinic over time.

Direct patient scheduling through use of online patient portals has the potential to provide patients with more autonomy on how, and when, they would like to be seen for specific reasons, including how long they would be willing to wait to see their own PCP. Indeed, an academic health center demonstrated that direct patient scheduling through online patient portals was associated with greater continuity with one's own PCP.[19] Use of the patient portal has also been associated with saved time when scheduling an appointment, helping patients feel more connected to their PCP,[20] and with positive patient experience scores.[21] Our data further support the notion that expansion of direct scheduling in primary care to allow more patient autonomy and transparency regarding PCP availability could have a favorable impact on patient experience.

Although these data highlight patient preferences regarding seeing their PCP vs other clinicians, including trade-offs between maintaining continuity of care and wait times, further research is needed to better understand the reasons for these preferences and the root causes for differences between groups. Investigations focusing on qualitative or mixed-methods analyses would help to better clarify the unique factors that contribute to individual preferences regarding primary care. Direct scheduling and the use of patient portals for asynchronous care has the potential to improve patient satisfaction and continuity with one's PCP, although more research is needed to evaluate the impacts of direct scheduling and the patient portal for primary care practices and the patients they serve.

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Key words: primary care issues: continuity of care; primary care issues: clinician-patient communication/relationship; primary care issues: patient-centered care; primary care issues: access to care/barriers to access; chronic care: patient preferences; healthcare team; allied health personnel

Submitted June 25, 2024; submitted, revised, October 31, 2024; accepted November 19, 2024.


Supplemental materials

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