

Continuity in a Changing Health Care Environment

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J Gen Intern Med 28(4):493–4
DOI: 10.1007/s11606-012-2294-z
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It's Saturday morning, and an otherwise healthy 35-year-old patient with a sore throat, cough and fever is concerned that she may have strep. She knows she will be unable to see her primary care provider (PCP) until at least Monday. With a busy week at work ahead, she decides instead to go to her local retail clinic, where she is seen by a nurse practitioner and preliminary results are negative for strep. Feeling relieved by the results, she does not bother calling her PCP.

In this issue of *JGIM*, Reid and colleagues address the impact of visiting a retail clinic on continuity with primary care.¹ Their study finds that patients who visit retail clinics once are more likely to return to retail clinics for subsequent care. Though patients experience decreased continuity with their PCP, they do not experience measurable changes in rates of preventive care or chronic disease management. The findings remind us that for many of the patients served by retail clinics and the conditions they treat, continuity may not be clinically necessary. As more patients receive care through medical homes and as retail clinics expand their scope of practice, continuity will likely take on renewed importance.

To assess the impact of retail clinics on continuity, it is necessary to disentangle the different dimensions of continuity—longitudinal, interpersonal, and informational—that may be disrupted when patients visit retail clinics.² *Longitudinal continuity* reflects the underlying principle of having a medical home where patients can receive the majority of their care over time. *Interpersonal continuity* encompasses the traditional model of a stable and personal physician–patient relationship. *Informational continuity* refers to whether all reports and communications regarding a patient are available to a physician at the point of care.

Longitudinal and interpersonal continuity may be compromised when a visit to a retail clinic replaces a visit to a primary care provider.³ The resultant discontinuity is compounded by the tendency of those who seek acute care at a retail clinic once to do so moving forward. And for those without a PCP, visiting a retail clinic may decrease the

impetus to establish care with a primary care provider, though it is currently unknown how often this happens in practice.

Retail clinic visits, however, do not invariably replace visits to primary care.⁴ Some patients would have chosen to receive acute care in an urgent care center or emergency room instead of visiting a retail clinic. Others may have forgone care or chosen to ‘wait it out’. The potential for induced demand in retail clinics—due in large part to their increased convenience—may be an important contributor to apparent changes in continuity. To the extent that retail clinics increase the total number of visits, it is possible that they may appear to lower claims-based measures of continuity without actually affecting visits to primary care. Reid and colleagues control for this possibility by removing visits for acute care from their calculation of continuity.

Related to this, it is unknown whether, by visiting a retail clinic initially and over time, patients feel less connected to their primary care provider. This may be considered in the context of a larger trend in care delivery in which patients receive their care from multiple providers, sometimes from different sites of care.⁵ Having a medical home may, in some cases, be more important than interpersonal continuity with an individual provider. Claims-based measures of care coordination that account for practice structure are important in this setting, as is measuring patient perceptions of continuity and its change over time.

In terms of informational continuity, communication flow is typically in one direction: retail clinics fax records back to the PCP.⁶ When the records reach the PCP's office, and whether the information is incorporated into the patient's larger medical records, is largely unknown. Retail clinics, however, do not have information readily available from the PCP and instead rely solely on patient history and their own electronic health record (EHR). In the setting of younger, often healthy patients and for limited, acute illnesses, this one-way flow of information may often—though not invariably—be sufficient for appropriate diagnosis and treatment.

While continuity is valued by patients and providers and is associated with lower health care utilization and costs, studies have typically examined continuity among patients with chronic conditions.^{7,8} Prior research suggests that continuity appears most important for older patients and those with multiple chronic conditions.^{9–11} Moving forward, we need to evaluate whether and to what extent

visiting retail clinics change outcomes among patients that may be most vulnerable to changes in continuity, particularly older patients, those on multiple medications, and those with chronic conditions. Reid and colleagues' focus on patients with diabetes is an important first step in monitoring the potential unintended consequences for chronic disease management and missed opportunities for prevention. However, longer term follow-up and additional measures of quality will be necessary to fully understand the potential impact. Moreover, future work should investigate how continuity may be affected for patients of different racial/ethnic groups and socioeconomic status, in order to assess possible disparities in access and quality.

In describing how visits to retail clinics may affect continuity, it is important to underscore that retail clinics may also present challenges to primary care practices and their patients beyond continuity. By removing a share of patient visits, retail clinics could harm the financial viability of some practices.³ Evidence for this is currently lacking and an alternative hypothesis is that physicians may instead be able to devote more time to complex and higher billing patients.

As retail clinics move to expand their scope of practice to include chronic disease management,⁶ different aspects of continuity may be increasingly important. It is unknown whether retail clinics will, for example, focus on behavior modification and medication adherence or titrate blood pressure and diabetes medications. In either scenario, increased communication and continuity with PCPs will be critical to managing patients over time, ensuring bidirectional flow of information, and defining clear roles and responsibilities.

Recognizing the trend toward convenience and the need for greater informational continuity as retail clinics expand their scope of practice, some hospital systems have established formal relationships with retail clinics.^{3,6} In certain systems, nurse practitioners may work at both the primary care practice and the retail clinic, and information may be shared directly through the EHR. Other organizations have chosen to integrate information systems without workforce sharing. These can serve as models in defining which aspects of these relationships may be beneficial for patient satisfaction and outcomes.

More broadly, health care reforms, including medical homes, accountable care organizations, and shared payment mechanisms are designed, in part, to reduce costs and improve outcomes by improving continuity. These models explicitly recognize the importance of attempting to align

incentives across groups of providers. In some models, interpersonal continuity with a single provider may take a backseat to longitudinal continuity with a provider team, whereas informational continuity will remain a key element. When designing and evaluating these new models of care, we will need to focus on which aspects of continuity matter most, for which patients, and for what clinical issues.

Acknowledgements: Dr. Siddiqui's salary was supported by an AHRQ NRSA Comparative Effectiveness Development Training Award (1T32HS019488-02). Dr. Pollack's salary was supported by a career development award from the NIH National Cancer Institute and Office of Behavioral and Social Sciences Research (K07CA151910).

Disclosure: Under an institutional consulting agreement with Walgreens, the Johns Hopkins University receives fees for advisory services. Walgreens owns Take Care Health Systems, a chain of retail clinics.

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