In a recently released issue of *Pediatrics*, Dr. Elizabeth Enlow and colleagues (10.1542/peds.2017-0339) looked at the very basic and endlessly fascinating topic of Continuity of Care (CoC). CoC has long been considered meaningful to both families and providers because it has been shown to increase satisfaction with care for both parties. 1-4 As Dr. Enlow and colleagues note, the question of whether increased CoC is causally related to improved outcomes has become even more important because the PPACA (Patient Protection and Affordable Care Act, also known as Obamacare) incentivizes the Medical Home by increasing funding to qualified centers. Does a Medical Home make a difference? Answering this question is difficult given the many potential confounders from sociodemographic qualities of families to organizational qualities of providers, as well as the challenge of selecting meaningful outcome measures (acute hospitalizations versus efficiency of screening for health conditions like anemia). We now can and should stand on the rooftops and shout out a resounding "Yes!" after reading this article. Medical Homes can save money, and economic data may be key to saving the PPACA, or at least its provisions that protect the most vulnerable citizens.

Trainees have several times raised the question of whether, how and if continuity matters in our own Continuity Clinic (the Pediatric Practice - PP), which serves a low-income predominantly African-American publicly insured urban population. A decade ago, one of our senior residents, Dr. Carla DeJohn, examined continuity over a 4 year period (2004-2008) among children ages 1-25 months: she reviewed 1,494 visits with 187 providers and included both well care and sick visits.5 She used the somewhat daunting Bice and Boxerbaum CoC (continuity of care) measure, because, as Dr. Enlow and colleagues note, it is a quantitative score that essentially "gives credit" if the child has continuity with several (not just one) provider(s), which can occur in many practices.6 As described by Flores et al, a Bice and Boxerbaum CoC score of 0 describes no continuity, <0.3 describes low continuity, 0.3-1 describes moderate continuity, and a "perfect" score of 1 indicates the child has seen only a single provider.7 Over the 2 year period, 44% of PP patients had moderate continuity (score of >0.3-1) and 6% had complete continuity (score of 1). In contrast to the findings of Enlow and colleagues, Dr. DeJohn found that neither rates of lead screening nor timely immunization, nor number of missed visits, were at all related to continuity of care level.

We took heart from this local (and unpublished) senior resident scholarly project. Both trainees and supervising physicians were pleasantly surprised to learn that 50% of PP patients had this level of continuity of care (moderate or complete), since many had predicted differently. Although we did not find that better continuity of care is related to improved screening and treatment, we actually were encouraged that providers were delivering the same level of care to all patients, and were compliant with guidelines for screening and vaccination.

Enlow and colleagues encourage readers to consider use of a continuity index as a quality measure to provide feedback to providers. Dr. DeJohn's senior project did just that for our trainees and supervising physicians. It
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also led to discussions about many strategies to increase continuity, especially for trainees who have just one day per week of clinic, and to several other resident scholarly projects related to aspects of continuity of care. Identifying the economic benefits of improved continuity is critical politically, and Enlow and colleagues have done this important work. Additionally, though, engaging in studying and examining continuity of care brings providers together and helps us re-energize our commitment to families and patient care.

References


- Development of a Curricular Framework for Pediatric Hospital Medicine Fellowships
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