

Enhance Care Continuity Post COVID-19

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The coronavirus disease 2019 (COVID-19) pandemic has tested the pressure points of health care infrastructure, financing, and delivery. Fears of contracting COVID-19 coupled with clinic closures have impeded the ability of patients to consistently receive care from a clinician or care team with whom they have an established relationship. Although shortfalls in continuity were well described prior to COVID-19, the pandemic has created an opportunity to augment this critical component of care delivery, with the potential to improve patient-centered outcomes and enhance spending efficiency.

Continuity, defined as a relationship with a provider or providers over a continuum of time that extends beyond a single illness or disease episode, encompasses 3 essential elements: (1) informational content (including knowledge of patient preferences and values), (2) management plans (which are often complex and require adaptations to ever-changing circumstances), and (3) relational value (which enhances current and future care decisions).^{1,2} A robust literature demonstrates that continuity is associated with better compliance with care recommendations, higher patient and provider satisfaction scores, and a more trusting and satisfying experience for patient and clinician.³⁻⁵ In addition, patients with a regular clinician experience decreased emergency department visits, inpatient admissions, and lengths of stay for those admissions; in certain circumstances, these quality improvements translate to lower medical expenditures.^{2,5-7} There is an especially high impact for the medically complex.^{6,8} This positive finding is reinforced by the study by Rajan and colleagues in this issue of *The American Journal of Managed Care*[®], concluding that veterans with diabetes who received less fragmented care experienced lower hospitalization rates.⁹

The identification of patient-level and systemic impediments to continuity preceded the pandemic, especially for patients with higher burdens of chronic disease, whose care crosses specialties and institutions.^{10,11} COVID-19 has further exacerbated barriers, which include:

- closure of primary care practices;
- a mismatched demand for and supply of clinicians able to take on the patient manager role—an unmet need that necessitates

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expanded panel sizes, which improve short-term access but may hinder access for existing patients^{12,13};

- postponed appointments due to safety concerns, limitations in management created by closures of ancillary medical services, and needed clinician coverage of inpatient services;
- a lack of interoperable communications among delivery systems, which has intensified as large independent delivery systems become the norm¹⁴; and
- the successful launch of autonomous telemedicine services that are not connected to a patient’s usual clinician.

The near-overnight implementation of virtual care effectively absorbed some of this demand for in-person patient visits. Results of prepandemic studies show that telemedicine improves access, limits distance/transportation barriers, facilitates the expansion of nontraditional hours of clinical care delivery, decreases missed appointments, and is associated with high rates of patient satisfaction.¹⁵ When expansions in access are implemented thoughtfully, there is some evidence suggesting that they improve continuity.¹² The pandemic motivated temporary expansions in insurance coverage that reimburse video- and audio-only visits at amounts equal to office visits, contributing to near-universal adoption and softening the negative financial impact of COVID-19 on medical practices. FAIR Health’s Telehealth Tracker estimated that claims for virtual visits increased more than 5000% nationally in May 2020 compared with May 2019.¹⁶ However, the impact of telehealth on continuity during the pandemic is unclear, especially for elderly and complex patients who may prefer face-to-face visits.

As care delivery is restructured following the pandemic, continuity should be encouraged, explicitly measured, and considered as a health system quality metric.⁶ Aligned incentives for providers and patients that augment continuity should become mainstream. Provider-facing elements include clinical payment bonuses, expanded roles of panel managers, and scheduling protocols that leverage the electronic health record to identify those with medical and behavioral complexity, psychosocial factors, and high health care utilization. Incentives for patients, such as lower cost sharing when seeing established providers—whether it be in person or with a virtual visit—are likely to add to their success. Interventions should prioritize medically complex patients who are likely to benefit most, clinically and financially. The potential for added revenues that result from quality bonuses and higher satisfaction scores could justify infrastructure investment and program monitoring.

The measuring stick of continuity—and care delivery as a whole—is the individual patient experience. Unexpected events such as COVID-19 and the resultant meteoric rise of telemedicine have created an opportunity to improve continuity of care, especially for our most vulnerable patients. Telehealth encounters—consisting of a medical record and a virtual patient history with no or limited physical exam—underscore the clinical nuance and intangible insights provided by an established patient-clinician relationship. As virtual visits become a permanent element of the “new normal,” continuity must be promoted, measured, and rewarded. Otherwise, the “continuity problem” will worsen, quality of care could suffer, and the proposed savings from fewer in-person visits will be diminished by duplicitous and potentially unnecessary care. Without this key element, patients will be less satisfied, and providers will be increasingly burdened with an unenviable and difficult task of providing safe, high-quality, and cost-effective care. ■

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