Continuity of care—which means receiving care from the same dedicated provider over time—benefits patients and our health care system. Strong continuity leads to:

- better health outcomes
- enhanced patient quality of life
- improved health system costs and efficiencies.

**Health outcomes**

Continuity of care is consistently associated with lower risk of hospitalizations, emergency department use, and/or rehospitalization including for home care patients and patients with dementia, diabetes, severe and non-severe mental illness, heart failure, and chronic conditions, as well as patients in the general population.

For patients with chronic conditions, better continuity of care can reduce the odds of being diagnosed with a second chronic condition or multimorbidity. For patients with ambulatory care sensitive conditions (ACSC; health conditions for which timely outpatient care could help to manage, reduce risks for, or even prevent the onset of), discontinuity of primary care is linked with increased ACSC hospitalizations.

Individuals with greater continuity of care also spend less time in the hospital with shorter lengths of stay.

Continuity of care can even have a protective effect against mortality and is linked to reduced mortality rates.

**Quality of life**

Patients with better continuity of care report better quality of life in their physiological, psychological, social, and environmental health. When patients see the same health care provider, they have greater patient satisfaction and better health outcomes, while patients with unmet health needs are more likely to lack attachment to a family physician.
Health care system cost

Investing in continuity of care can result in improved health system cost and efficiencies. The higher primary care costs stemming from strengthening continuity of care are more than offset by a lower total cost on the health care system. This includes lower surgery costs, costs per medical visit, and less use of emergency departments, intensive care units, acute patient care, and long-stay long-term care homes.\textsuperscript{22,23,24,25}

Patients who regularly receive primary care are less likely to be frequently hospitalized,\textsuperscript{26,27} and hospitalization costs outstrip visits to primary care several times over. For example, in Canada the average visit to a primary care physician in a fee-for-service model costs $51.01 while the average hospitalization cost is $6,349.\textsuperscript{28}

Continuity of care has a host of benefits—it is time to act to strengthen the primary care system to enhance continuity for all in Canada.

The Patient’s Medical Home is a vision for the future of family practice, where collaborative care teams provide high-quality, patient-centred, and continuous care. Key aspects of this model include timely access, health care system integration, and connected care.

How can we improve continuity?

Access
Almost five million patients in Canada still lack access to a regular primary care provider.

- Invest in strengthening and expanding primary care in Canada to ensure everyone has access to a family doctor.
  - In Nova Scotia, the province is targeting funding to improve access to primary care—\$7.3 million is being invested in a blended funding model to allow family physicians to take on more patients, while \$2.7 million is allocated to physicians providing in-patient care in larger community hospitals to support care at all hours of day

Integration with other care settings
Team-based care allows for reduced wait times to access care and enhanced care coordination.\textsuperscript{30}

- Support further development of interprofessional teams to facilitate integrated care across a variety of settings including community practices, hospitals, and long-term care homes
  - The Northwest Territories’ Health and Social Services Authority has proposed ‘Virtual Integrated Care Teams,’ where co-located interdisciplinary teams offer continuous care through a mixture of in-person family physician community visits and virtual/remote support from other health care professionals within each team\textsuperscript{31}

Connected care
Interoperable electronic records, e-scheduling, and other digital infrastructure promote continuity of patient information for care providers and efficiency of care.

- Make information and communication technology supports widely available and accessible to health care teams across settings
  - In Prince Edward Island the government has invested \$8.4 million in an electronic medical record project that will establish a common platform for community-based health care providers\textsuperscript{32}
Endnotes

8 Toulany A, Stukel TA, Kurdypak P, Fu L, Guttman A. Association of Primary Care Continuity With Outcomes Following Transition to Adult Care for Adolescents With Severe Mental Illness. *JAMA Netw Open*. 2019;2(8):e198415.


