Comprehensiveness of care

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Dear Colleagues,

I am on record as indicating that our graduating family medicine residents should be ready to provide comprehensive care and that this means being able to see all men and women of any age, for all presenting problems; to provide superb follow-up; to look after individual patients, as well as a defined population; and to work in more than 2 practice settings (eg, office and home). Your board recently identified the support for continuity and comprehensiveness of care (C3) as the most important challenge facing our profession and the CFPC. There are days when I wonder whether my view of comprehensiveness is "passé."

In 1996 the Institute of Medicine defined *comprehensiveness* as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs."[1] Common themes associated with comprehensiveness include continuity of care, being the point of first contact for undifferentiated illness, and coordination of care.[1] Many will say that the increase in complexity of care, attending to comorbidities, and the evolution of interdisciplinary models of care make it less likely (or impossible) for family doctors to assume and sustain such responsibilities.

In a study reported last year, Bazemore et al looked at health care costs and hospitalizations in relation to the degree of family physicians' comprehensiveness of practice. Comprehensiveness was characterized using the American Board of Family Medicine's measure of comprehensiveness, as well as the Berenson-Eggers Type of Service codes.[2] The authors were able to demonstrate that increasing comprehensiveness of care was associated with lower Medicare costs and fewer hospitalizations. The study limitations included a lack of information about the quality of care provided and the patient experience with care. Another study, conducted at the Peterson Center on Healthcare, showed that primary care practices that were "positive outliers" (ie, delivered high-quality care at lower-than-average cost) had a greater likelihood of having primary care physicians with a more comprehensive scope of ambulatory care practice (including, for example, dermatologic and orthopedic procedures).[3]

The College's challenges with C3 were briefly described at our first annual forum in early June, attended by 130 family medicine leaders. It was pointed out that, given the dynamic forces affecting health care at the moment, views regarding what *comprehensiveness* means might vary. In North America, many physicians identify multiple practice settings as an important component of comprehensiveness. In Europe, with a denser population base, a family physician's practice setting is much more likely to be community based, with consultants in other specialties working primarily in the hospital. A comparative study showed that US family physicians are almost twice as likely as their British counterparts to refer to other specialists for an opinion. This difference was not explained by differences in the disease burden. This led the authors to suggest that British GPs might have a more comprehensive scope of practice in the ambulatory setting than US family doctors do.[4]

During my "corridor consultations," some annual forum participants expressed that they thought comprehensiveness needed to be reframed as the comprehensiveness *of the practice.* One would not expect that each individual practitioner could "do everything"; however, there should be a complementarity of the clinicians in the practice such that the group can be responsive to community needs—that an understanding of the population being served should help guide the composition of the group, as well as the kind of teamwork that needs to be put in place to best meet the needs. In order to best work out the different elements of the organization of the practice, clinicians need to be accountable to each other, in addition to their group accountability to the population being served.

There has been ongoing discussion about enhanced skills and concern about the risk of "mini specialization." Although it is recognized that a certain proportion of family physicians will have focused practices, many elected leaders hope that the evolution of models of care can facilitate a better integration of family physicians with special interests and enhanced skills in comprehensive practices, as described above.

I look forward to reading and hearing your thoughts about C3.

Finally, I'd like to offer a reminder that you are invited to cast your vote for 3 new Directors-at-Large for the board and for the positions of President-Elect and Honorary Secretary-Treasurer by electronic voting this year, between October 13 and November 2, 2016. Further information will follow.

Cet article se trouve aussi en français à la **page 607.**

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References

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