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The Impact of Patient Centered Medical Home on the Patient's Experience

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The Impact of Patient Centered Medical Home on the Patient's Experience

BY

Courtne Flynn

SUBMITTED IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE OF
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Abstract:

Patient-Centered Medical Homes (PCMHs) are transforming the primary care practices. It is now turning into what patients want (as well as what they need), focusing on specific patients themselves and every single one of their needs. This makes the patient experience only that more important. Across the world patients' perspectives of what constitutes quality in terms of the delivery of their primary care are increasingly recognized as essential in improving the patient experience. This study lays out the experience of patients at one patient center medical home in Flatiron, Manhattan. During this paper we will answer the following questions: 1) what are the attitudes of patients on the quality of care they receive at their patient center medical home? 2) What characteristics are associated with positive variability in patient experience? 3) What factors that are in control of the PCMH can be modified to improve patient experience? This medical office has outsourced the data collection of all of their sites. The collection service data is collected through telephone and paper-and-pen surveys. The people that are called or sent the surveys are selected at random. This data is analyzed through narratives with some quantitative data expressed in trends, percentages, charts and graphs. The attitudes of the patients on the quality of care they received were always above 80%. Access, work flow (moving through their visit), nurse/assistant, care providers, and personal issues are all contributors of a positive experience and are all in control of the PCMH. The study demonstrated that if health care providers and patients participate in an effective PCMH, they would better equipped and more willing to address both their medical and social issues. Therefore, improving both the patient and their community.

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Chapter One: Introduction

America has struggled throughout the years with developing their health care system to be patient centered. The avenue to push this effort has been patient centered projects like the Patient-Centered Medical Home (PCMH). The PCMH concept was first introduced in 1967 by the American Academy of Pediatrics as a model of primary care, specifically for children with special health care needs (Grant and Greene, 2012). It was initially intended to help coordinate multidisciplinary services from a multitude of sources (Willis, Hoy and Jenkins, 2011). Later, it was expanded by the American College of Pediatrics in 2002 and subsequently adopted by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association and the American College of Physicians (Healthcare Financial Management, 2010). When it was adopted it was defined by a variety of principles such as: personal physicians, physician-directed medical practices, whole person orientation, integrated and/or coordinated care, quality as well as safety, enhanced access and payment recognizing the value of added service (Healthcare Financial Management, 2010). However, not much has changed. Hyman and Johnson (2012) proclaimed that PCMH practices are accessible, family-centered, developmentally appropriate, continuous, comprehensive, coordinated, compassionate and culturally sensitive. It is important to note that in order for a PCMH to be successful that each one of the branches has to exist together.

To breakdown each branch of the PCMH, accessibility refers to how accessible clinics, medical centers, and doctor's offices are by foot, car, bus, and rapid transit (Cox, Buman, Woods, Famakina, and Harris, 2012). Family centered allows patients family

focus groups that make care available for every member of the family and even members not in the direct family receive social services and referrals for medical care (Cox et al., 2012). This allows PCMHs to be a community effort. Developmentally appropriate refers to the staff working with the patients. They should have expertise with the age group(s) and be able to help them meet the various milestones in their lives. Continuous means that each patient and family gets a designated social worker or care coordinator and a medical provider so they aren't working with different people every time they come into their PCMH or medical facility. Comprehensive allows them to provide wraparound services including medical care, social services and referrals to community-based resources. Coordination refers to directly linked care through regular staff meetings or subspecialty medical appointments. Compassionate refers to the staff being trained to focus on understanding individuals and being trained to communicate effectively. Finally, culturally sensitive refers to having teams composed of a diverse group of male and female provider who are of all racial background. All staff should also be given diversity training to make them well rounded and educated on how to address everyone they work with cultural differences. All these components in the PCMH have great potential to improve the health and quality of life but how about the patient experience?

Today's health care system is very complex for all parties involved. It is significantly different than *what it used to be*. The changes are many and represent the major shifts within the health care system, especially in regard to patient experience (or satisfaction). "The U.S. health care system has been described as a non-integrated entity with variable performance and largely unmeasured outcomes" (Savage, Lauby

and Burkard, 2013). Therefore, it is critical to understand how patient experience tie directly with healthcare. Across the United States (and many other countries) patients' perspectives of what constitutes quality in terms of the delivery of their primary care are increasingly recognized as essential in efforts to assess and improve the patient experience. If patients are not satisfied with their experience and are not engaged with their healthcare providers, then healthcare is unlikely to be successful in improving health (Kern, Dhopeswarkar, Edwards and Kaushal, 2013). For many years the main way that patients' views on primary care performance have traditionally been sought has been through the measurement of overall evaluation of care questionnaires of perceived service quality and particularly the patient's satisfaction. More recently it has been argued that questionnaires should address and ask patients about concrete experience and an overall evaluation. Aspects of patient's experience (of healthcare) include (but are not limited to) their perceptions of: the quality of their relationship with each one of their providers, the quality of disease management, access to care and the communication they have with office staff.

Efforts are under way across the country to improve healthcare. Part of this focus is improving patients' experience. "One of the most common approaches, with more than 100 demonstration projects under way is the Patient-Centered Medical Home (PCMH)" (Kern, Dhopeswarkar, Edwards and Kaushal, 2013). The National Committee for Quality Assurance (NCQA) also supports these principles and makes sure that the PCMH strengthen a long term, coordinated care between physicians and their patients (Savage, Lauby and Burkard, 2013). Practices only receive NCQA recognition when they have implemented a specified number of patterns of processes of care, with

different levels of recognition depending on the number and pattern implemented (Kern, Dhopshwarker, Edwards and Kaushal, 2013). It is believed that patients who receive care through a PCMH have access to the medical provider by telephone and have open access to care at any time of the day will have a better patient experience and be more than satisfied with their care.

Medical advances have created rising patient expectations and the complexity of health care has continued to grow. It has specifically addressed the patient's experience. The importance of addressing patients' experience is to be able to assess the value of patient satisfaction with interventions, particularly in situations where only the patient has direct knowledge of treatment benefit. Patients' perspectives on the symptoms they experience, how they feel and function, and their quality of life associated with their health condition and its treatment may be measured with thorough survey and intense questionnaires.

The concept of patient experience, as contrasted with the more generic patient satisfaction pertains to how patients themselves perceive specific aspects of the care, which they receive from their providers. In contrast to patient satisfaction, patient experience is thought to be a more useful indicator of quality because it provides a clear base line for actionable improvement (Jenkinson, Coulter, Bruster & Richards, 2002).

This study will focus on the aspect of patient experience with an aim to measure their experience in a primary care practices setting that is NCQA recognized for their PCMH for a general adult population. This population will be going to a medical home in Manhattan, in the Flatiron District to be specific. Generally the Flatiron District can be said to be bounded by 20th Street, Union Square and Greenwich Village to the south;

the Avenue of the Americas (Sixth Avenue) or Seventh Ave and Chelsea to the west; 25th Street and NoMad to the north; Rose Hill to the northeast, and Lexington Avenue/Irving Place, Gramercy Park to the east. Patients range in ethnicity, age, education level, social class, and economic class. The research is designed to answer the following questions:

1. What are the attitudes of patients on the quality of care they receive at their patient center medical home?
2. What characteristics are associated with positive variability in patient experience?
3. What factors that are in control of the PCMH can be modified to improve patient experience?

Chapter Two: Literature Review

This study will address the growing concentration on patient experience. Across the United States in many healthcare settings there has been a push to address the patients concerns and issues. This goes beyond patient satisfaction but opens a whole other world for the patients' role with each and every one of their providers. This change is to benefit the patient and also shows how the healthcare sector has changed. Healthcare used to be organized around the wants and needs of the providers. However, now that the market has become very competitive and the consumer (the patient) now has even more options available to them, the focus has become the patient.

To address a growing interest in assessing patient experience with the patient-centered medical home model, many medical groups have had to implement various new concentrations within their sites. It is no longer just about the relationship between the patient and provider at the site; it is now about the interactions with every person that is involved with the patient. This includes the receptionist, medical assistant, nurse and administrative staff in many situations. The patient experience is measured on a number of things. It includes some of the following: Access which means getting a timely appointment, care, and information. How well the providers communicate with their patient. How helpful, courteous and respectful office staff is with the patient. What the patient's rating of their provider is, as well as, the provider's attention to a child's growth and development (this is for pediatric cases only). It also offers three new composite measures. Each of these only pertains to adults. Does the provider pay

attention to your mental and emotional health? Does the provider support you in taking care of your own health? Does the provider discuss your medication decisions?

In contrast to patient satisfaction, patient experience is thought to be a more useful indicator of quality because it provides a clear basis for actionable improvements (Jeankinson, Coulter, and Bruster, 2002). We focus on each of these aspects of the patient experience accessible, family-centered, developmentally appropriate, continuous, comprehensive, coordinated, compassionate and culturally sensitive. It is important to keep in mind that patient experience is so different from patient satisfaction because it pertains to how the patients perceive each one of these specific aspects of their care.

Interpersonal exchange combines family-centered, developmentally appropriate, continuous, comprehensive and coordinated – just about each one of the elements that define a PCMH. It is determined by how actively the patient participates in decision-making and how often physicians seek feedback to ensure that the patient's expectations are being met (Martsolf, Alexander, Shi, Caslino, Rittenhouse, Scanlon and Shortell, 2012). A positive interpersonal exchange takes place when a provider (or their staff) spends time listening to patients, develops whole-person knowledge, explains everything clearly and provides information that the patient both wants and needs to be successful in their healthcare journey. These experiences help patients transition from their traditional role to one where they participate more actively in the decision-making process. "Empirical evidence suggests that high quality physician communication with patients has been linked to higher levels of patient adherence to treatment plans, improved self-management of disease, greater recall of important

treatment information, and improved mental and physical health status” (Martsolf, Alexander, Shi, Caslino, Rittenhouse, Scanlon and Shortell, 2012).

Treatment goal setting combines many of the following: developmentally appropriate, continuous, comprehensive, coordinated, compassionate and culturally sensitive. This also involves joint physician-patient decision-making. It is in place to develop clear and agreed upon care plans that specifically incorporate the preferences of both parties. When the patient and the provider can work together to create these treatment goals, the likelihood of the patient following the necessary steps to better their health increases.

Out of the office contact is also a principle of the PCMH. Enhanced access to care should be available through appropriate options of communication between the patient and their personal physician and practice staff. A great example of this has been medical portals. They give patient direct access to their charts, lab results, and direct emails to their providers. The importance of out of the office contact is supported by the fact that about one-fifth of U.S. adults reported that they do not get “enough time” with their physician during an office visit and another half said they had difficulty understanding instructions they received from their provider’s office (Kaiser Family Foundation, 2005).

Medical care through a PCMH has been associated with better health status, family centeredness, timeliness of care and improved family functioning (Golnik, Scal, Wey and Gaillard, 2012). A PCMH called Group Health Cooperative of Puget Sound in Washington saw a twenty-nine percent reduction in emergency room visits under its patient center project (Wood, 2012). The “community care of North Carolina save \$135

million in Medicaid and State Children's Health Insurance Program costs, and another \$400 million in care for the blind, aged and disabled in just one year" (Wood, 2012).

The amount of money we could save would be tremendous if everyone put a hand in to help the ones around him or her. In addition, a PCMH named Qliance was launched in 2007. They analyzed their data from 2009 and 2010 and found that they had a 65% reduction in emergency room visits and a 43% reduction in hospital days (Wood, 2012). They also captured data that showed a reduction in the specialist visits by 66%, advance radiology by 63% and surgeries by 82% (Wood, 2012). It should be noted that these changes did mean a huge increase in primary care visits. The regional average per person doubled what it typically had been (Wood, 2012). However, for cost and effective care, that change is also not a bad one. It is a change that the healthcare market should embrace.

In an effort to focus the country's attention on ways to gain a higher quality of health care, the Department of Health and Human Services unveiled the National Strategy for Quality Improvement, which was a strategy that has three aims. Their three aims were improving quality by making health care more patient-centered, accessible and safe; improving health with proven interventions; and reducing the cost of goals (Healthcare Financial Management, 2011). These strategies line right up with the goals of a PCMH. The PCMH also asserts with confidence the ability to improve care while they decrease costs.

However, in order to make health care more patient center there needs to be an integration of care across medical, educational and social service systems. This is challenging to both families and health care providers due to the time required, cost of

staff time and services, knowledge, training, availability of services, and lack of support for the collaborative effort itself (Hyman and Johnson, 2012). This is especially challenging when organizations that the PCMHs work with do not have lines of open communication with the other health care organizations around them. Their web of resources is going to be very limited which makes care coordination even more difficult. Also Health Insurance Portability and Accountability Act (HIPAA) laws made it increasingly difficult to share information between medical offices, facilities, clinics, rehabilitation centers, etc. In order to obtain or share information of the member or patient he or she needs to sign the consent or the requesting party has to be the paying agent (such as the insurance company). This is made especially difficult when the members of the PCMH that need the coordination of care don't understand the mission or the effort and are not comfortable with the PCMH reviewing their medical history so they limit or deny their access. This is why it is very important to build those relationships with the members and the community. So, that there can be open lines of communication and the deep underlying issues can be addressed because the patient will feel okay with expressing it. What is important to note is that care coordination and care transitions are addressing change over time so it is not just what is happening right now we also need to address what occurred that made the patient end up where they are (Levine and Feinberg, 2012-13). This means that the PCMH also has to address future needs as well.

Accessibility to healthcare has been an issue in the United States across the board. Individuals lack transportation to medical facilities (including their PCMHs). There is also a shortage of specialist and primary care physicians (Muñoz, Nelson, Bradham,

Hoffman & Houston, 2011). The primary care physicians that are local are usually very overwhelmed and have limited time. This prevents them from giving every patient of theirs the proper care coordination and their true attention on all their medical needs. We have stressed the need of the PCMH members going to their primary care physicians and specialist instead of hospitals. However, Wright and Knopf (2009) reported that with their members who had a sensitive diagnosis (HIV, AIDS, herpes, etc.), they were more likely to have poor attendance to appointments. This was because their clients reported that they were uncomfortable receiving care at centers known for providing care to those diagnoses because their family or friends would more readily identify them as being seropositive through their association with these centers. This is an issue that a PCMH could address by coordinating their care elsewhere. This also stresses why it is important to have open lines of communication with the PCMH members so these issues can be addressed.

Another challenge is finding the proper staff. The PCMH needs to find community health workers or medical professionals that can be enabled to become collaborative leaders and have the desire to dramatically change health care from “sickness care” systems to a system that provides comprehensive care for both their individual patients and their families as well as the community through tribal wellness (Balcazar, Rosenthal, Brownstein, Rush, Matos and Hernandez, 2011). These positions usually require fieldwork and people who are very committed to the communities in which they work. They generally have great ties and are very persuasive when it comes to pushing the community to make the correct health decisions. These are not easy positions and can be very difficult to fill.

The staff has access to a lot of people's medical history. However, the reality is that it would be very hard, almost impossible for physicians and other provider to work the amount of care coordination necessary into a standard fifteen-minute appointment. Throughout the years physicians have cut the time they spend with their patients so that they could number one, see more patients within a day and because of some of the necessary paper work they are required to fill out now. Also, many practitioners still operate under the belief that the more procedures they do the more money they will get back. Therefore, they would never see the need to devote the amount of time necessary on one patient (or a family); so, implementing a PCMH in their practice would never seem beneficial to them. In addition, the majority of these offices do not have the resources take on the workload that most PCMH require. They obviously lack the time necessary in most standard office visits for assessment and counseling, not to mention they lack the capacity that is necessary for care coordination due to insufficient expertise in general (specific with behavioral management). In addition, most primary care physicians have inadequate staffing for screening and lack reimbursement, lack of practice guidelines, and skepticism by families of traditional medicine or vaccines (Hyman and Johnson; 2012).

This does not mean that the primary care physician offices that are staffed properly and have all the necessary resources aren't capable of having their own PCMHs. Today many doctors' offices are just known to get their patients in and out while using the least amount of time and resources necessary. However, for the ones who can support these type of programs there have been a few of them who have hired personal health nurses for each primary care physician and hired another organization

to come in and provide an orientation of the program and the tools necessary to manage the care needed for their members. In order to promote these changes they typically have to come from an outsourced company because it is changing the mindset of the people who work within the office as well as the office culture.

Another challenge of the PCMH is coordination of care. When there are too many hands involved or when there is a lack of care coordination this leads to an overuse of services (examples: duplicate tests, readmissions). This has tried to be address by hospitals by requiring them to reduce readmission rate. This makes hospitals address care coordination not only within the hospital but post-hospital visits as well. Another issue this causes is the communication issue that is between hospitals (outside physicians) and PCMHs that aren't connected to the hospital. How would anyone know that their patient is in the hospital without having access to the hospital claims or inpatient clental? The PCMH would not know unless their member or a member's family member reached out, if they were present when the member went to the hospital or they made the recommendation. This is an issue because it leaves full responsibility of care coordination to the hospital and hospitals usually don't have the staff to do the follow up coordination once a person is discharged. Then, the PCMH would have to rely on the individual to communicate what happened to them and what was recommended to them from the hospital professionals to the PCMH, their primary care doctor and any specialist they are seeing. So care coordination is crucial but can also cause a lot of headaches for the PCMH coordinators and everyone else involved. This brings up the issue that a lot of hospitals lag behind other medical industries in adopting information technology that facilitate the exchange of information's among providers. The lack of

information related to prior treatment plans, tests and procedures often leads to duplications and unnecessary delays in treatment. Care coordination is one of the largest opportunities to reduce cost while increasing the value of the given services. This issue could be addressed by an electronic medical record, which would have the local PCMH roster already uploaded within them. The member would have signed consents previously during the time that they were assessed. So when the patient is admitted to the hospital their PCMH coordinator or medical professional can be notified of what is going on and work with the hospital staff to coordinate post-hospital care.

As previously stated a large issue with running a PCMH is a lack of communication among the PCMH and hospitals, clinics, primary care physicians, specialist etc. When information is passed on through so many individuals it is easy for it to get contorted. The least amount of people involved within the case the better. Not to mention, when so much information is being given to the patient who might just have received a chronic diagnosis and is seeing multiple doctors a week it gets very hard for them to remember everything.

Another issue is that sometimes doctors aren't able to communicate with the correct verbiage so that their patients can understand them. It is sometimes necessary to have an interrupter (a coordinator, or nurse) to break down what the doctor is saying. It is important to note that everyone has a different level of literacy. To address this communication issue, every individual or family enrolled within a medical home should be assigned one care coordinator or community worker and one nurse to address all their issues. This also increases the opportunity for shared decision-making. This is when patients take an active role in making informed choices about their care. It allows

them to make a decision for themselves instead of only relying on what their doctor is saying because doctors don't always know what is best. This also allows for strong ties to form and opens lines of communication with the patients and staff. When the patient builds trust with the people that are working with them it may be easier for them to express their true concerns and issues that they are facing.

The PCMH team is also striving to reorganize the health delivery system and improve the quality of care provided to all (Northridge, Glick & Metcalf, 2011). They have a goal to improve health of their patients as well as their quality of life. The PCMHs even increase the profitability of primary care physicians and specialist; by directing the care of their patient to them instead of emergency rooms, urgent care centers and hospitals. By doing this there is typically an increase of visits to these doctors (visits to primary care physicians and some specialists cost less than repeat visits to hospital emergency rooms and urgent care centers).

In order for a PCMH to work efficiently there has to be the correct Information Technology System (or Electronic Medical Record system). This system would collect, store, manage and be able to exchange relevant health care information between the PCMH and the healthcare facilities. By using an informative technology system that can make these connections with other facilities, the PCMH will facilitate or even enhance communication between providers, members, and the care teams for care coordination, care delivery and care management. The system would also be an important tool that would collect, store, measure and report on the outcomes and process of each individual enrolled in the PCMH; as well as the population performance and their quality of life. The system would also allow multiple doctors to have a say in treatment by giving

them all access to test results and available treatments. Most importantly, it will inform the members about their health and medical conditions as well as facilitate their self-management with input from providers. This system would benefit practitioners because it would give them all an open door of communication and allow them support in decisions they make. It would also allow for each practitioner to know what the other one is doing with the patients that they share. This will also free up a little bit of time because they will not have to duplicate the same test more than once. PCMH are an extreme benefit to primary care physicians and specialist. For the most part they are getting a medical team. They are just another set of hands and eyes to make their jobs easier. It ultimately benefits not only the patient but also everyone involved.

Chapter Three: Methodology

The purpose of this study is to test the hypothesis of Golnik, Scal, Wey and Gaillard (2012); they stated that medical care through a PCMH has been associated with better health status, family centeredness, timeliness of care and improved family functioning. The following questions will guide this study: 1. What are the attitudes of patients on the quality of care they receive at their patient center medical home? 2. What characteristics associate positive variability in patient experience? 3. What factors that are in control of the PCMH can be modified to increase patient experience? The purpose of this study is to determine if the PCMH should expand and become a basic model.

To answer all three questions this study will be analyze a population of patients that go to a medical office in the Flatiron District in Manhattan, New York; however, it should be noted that patients come from all over the tri-state area to go to this medical office. The regular office hours of this site are: Monday through Thursday eight o'clock am to eight o'clock pm, Friday eight o'clock am to five o'clock pm and Saturdays nine o'clock am to noon. This site offers appointments, walk-in and same-day services to their patient and their servicing community. This office is staffed with four family medicine physicians and one family nurse practitioner. There is also a full time podiatrist on staff. Then, there is a variety of rotating (part time) specialists such as: ophthalmology, nutrition, obstetric, gynecology, gastroenterology, endocrinology diabetes and metabolism. The insurances accepted at this site are: Aetna, Affinity Amerigroup, Cigna, Comprehealth, Easy Choice Health Plan on NY, Elder Plan, Emblem Health, Empire BC/BS, Fidelis, GHI, Health First, HIP, Humana, Local 1199,

Magnacare, Medicaid, Medicare, Oxford, POMCO, Tricare, United Healthcare, and VNS Choice. Therefore, the population of this study will encompass a variety of ages, races, economic statuses and educational levels.

This medical office has outsourced the data collection of all of their sites. The mission of the collection company is to help medical facilities to deliver high-quality, efficient care and improve the patient experience. They do this by capturing the voice of the patient through innovative techniques and then their advanced analytics and expert advisors recommend improvements to clinical, operational, financial and experiential outcomes. Recommendations are given by listing tips and advice for all parts of the staff (physicians, providers, medical assistances, nurses, administration, etc.) to improve patient experience. This helps give the medical facilities the confidence to make changes, based on proven best practices, to achieve operational excellence. It also enables the medical facilities to see and understand every dimension of the patient experience. They reveal opportunities to improve quality, increase market share, operate efficiently and optimize reimbursement.

The type of empirical research that is offered is a survey study. The design of this study is some sampling; static group comparisons; and narrative analysis used in applied research. Data can be collected through interview questionnaires, focus groups, document analysis, minutes and video and audiotapes as well as emails. However, the collection service data is collected through telephone and paper-and-pen surveys. The people that are called or sent the surveys are selected at random. They take the list of patients who kept their appointments and randomly select who they will call and send out surveys to. This data is analyzed through narratives with some

quantitative data expressed in trends, percentages, charts and graphs. The time frame for most surveys is one to three months. The ethics of this study is generally low because in majority of the cases the data that is collected is gathered on a voluntary basis.

The general topics of *Medical Practice Survey* are: Access, Moving Through Your Visit, Nurse/Assistant, Care Provider, Personal Issues and Overall Assessment. Each section follows with between 4 – 11 questions; and asks the patient to rank their experience from a 1 (very poor) to a 5 (very good). Every section also allows for open-ended answers in the comment section that follows. The data collected is analyzed and can be broken down by each section of the survey, for each site, for each provider, by month, by year, organized by visits or received data, etc. This data is shown in narratives, charts, graphs, pie charts, etc. I myself will collect data on each section and only at the Flatiron District Office. I will present this information in narrative as well as charts.

The limitations of this study are that this medical office chain currently employs me. I also, work at the Flatiron District Medical Office. My job requires me to spend quite a significant amount time analyzing data collected by the collection agency. However, I'm more than confident that I could keep the external validity low in this study because I'm not the individual collecting the data and the majority of the analytical information can be supported by the work of the outsourced company. That is also how I will be able to control objectivity over subjectivity. The internal review board of this medical office will address the ethical concerns of this study.

Chapter Four: Findings

In this chapter the findings of the data collected are displayed. The data were assembled and arranged in order to respond to the problems raised in chapter one. Two crucial objectives steered the data collection and the following data analysis chapter. The goals were to establish the attitudes of patients on the quality of care they receive at their patient center medical home; the characteristics that are associated with positive variability in patient experience; the factors that are in control of the PCMH that can be modified to improve patient experience.

Questionnaire one used a survey that was designed based on helping support health care providers in understanding and improving the entire patient experience. Three hundred and six (393) questionnaires were received either through mail or telephonic conversation. The questionnaires were collected from January through April this year. The breakdown of questionnaires completed from each month are as follows: for January there were 93, February there were 103, March there were 81 and April there were 116.

The respondents were asked to reflect: what are the attitudes of patients on the quality of care they receive at their patient center medical home? This was first seen through the overall experience with the PCMH; which was shown in Figure 1. This information was collected by averaging out each one of the sections in the questionnaires they filled out. Figure 1 also gives the percentage out of hundred that the patients on average ranked their experience monthly. The lowest overall score was recorded in March at 82.4% and the highest overall score being the 86.7 in both January and April. A commentary box was also provided in order to add any further

remarks. Some respondents stated that the PCMH offered an overall good experience, however the prescription/referrals (follow up) needs to be button down. Whereas, another respondent stated: my number one complaint if you have an emergency you cannot see the doctor; number two once you have an appointment and it has been cancelled it takes a long time to get another.

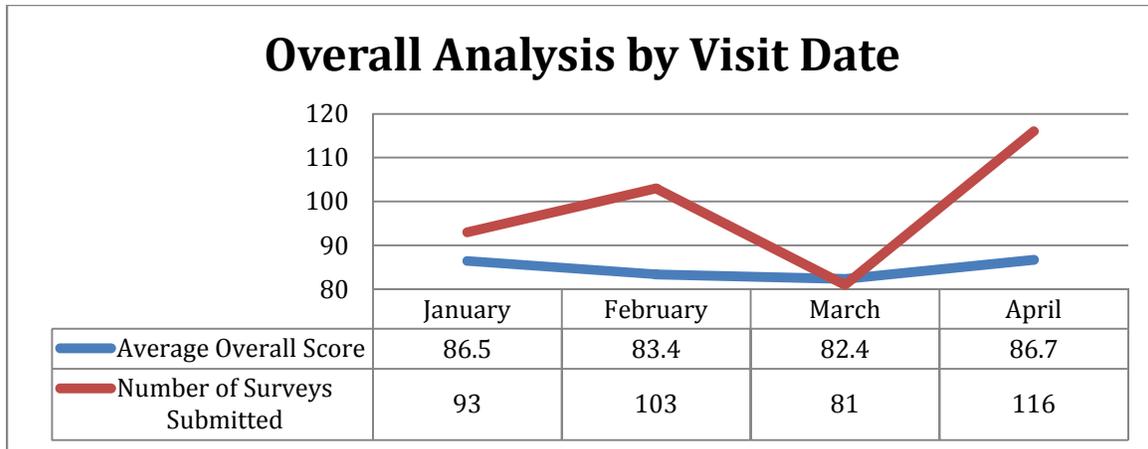


Figure 1. Trends on the Overall Medical Visit at the Patient Center Medical Home; January - April of 2014.

The first section addressed in the questionnaire was on access. There were six questions asked to address the concerns of the respondents (Figure 2). They pertained to: ease of getting through to the office on the phone, the convenience of the office hours, ease of scheduling your appointment, courtesy of the person who scheduled your appointment, courtesy of person who scheduled your appointment; and the ability of getting an appointment for when you wanted. These questions contributed to the overall score of the PCMH.

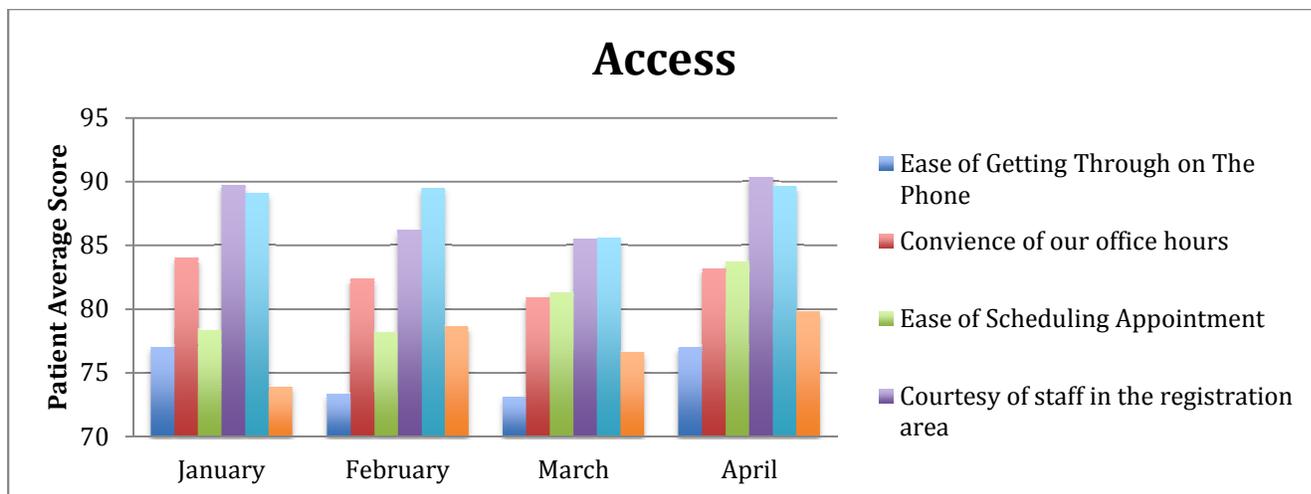


Figure 2. Trends on Access in the Patient Center Medical Home; January through April of 2014.

When asking the respondents about the access of PCMH in regard to ease of getting clinic on the phone, the PCMH scored the lowest (see figure 2). However, the courtesy of the staff in the registration area and the courtesy of the staff did very well for every month. With scores that ranged from 85% - 90.3%. There were also a few comments left every month. A patient proclaimed “no bad experiences. All my experience were good;” whereas, another patient states “I couldn’t believe it took 3 weeks to get an appt.”

Respondents were asked about their personal experience and how they felt moving through their visit (figure 3). This section of the questionnaire asks the respondents what degree to which they were informed about any delays; wait time at the office; length of wait before going to an exam room and waiting time in exam room before being seen by the care provider. In the open commentary section respondents expressed concerns such as “after registration it was unclear where to go and the estimate wait time.” However they also shared “I was on time for my appointment. I

waited until my name was called I was in the examining room in out. I was able to make it to my next appointment in a timely fashion.”

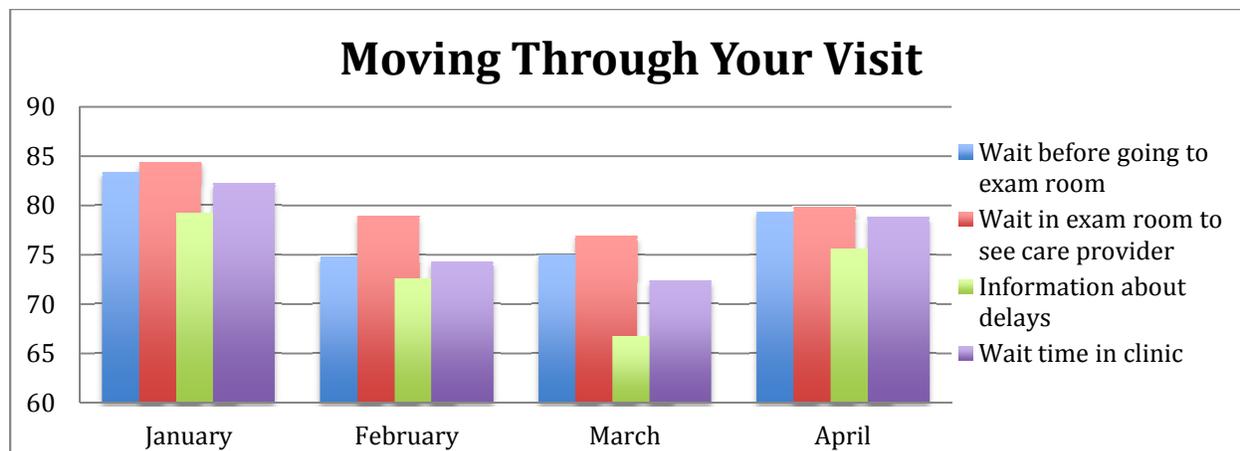


Figure 3. Moving Through the Visit Breakdown at the Patient Center Medical Home; January through April of 2014.

Respondents were asked about the nurse or assistant that helped them throughout their visit (see figure 4). This person is the clinical person that took part in their visit other than the provider. The two questions the respondents were asked to rate were their experience on: the friendliness and/or courtesy of the nurse or assistant and the concerned the nurse/assistant showed for your problem. The open comments in this section ranged which is expected since we are evaluating different people. They went from “the general experience was very professional and kind” to “assistant was aloof made no emotional connection. Did not smile, was not friendly. Lazy, couldn’t make an effort to write extra information down. Came across as if she just did not like people. She just wanted to go home, came across cold!”

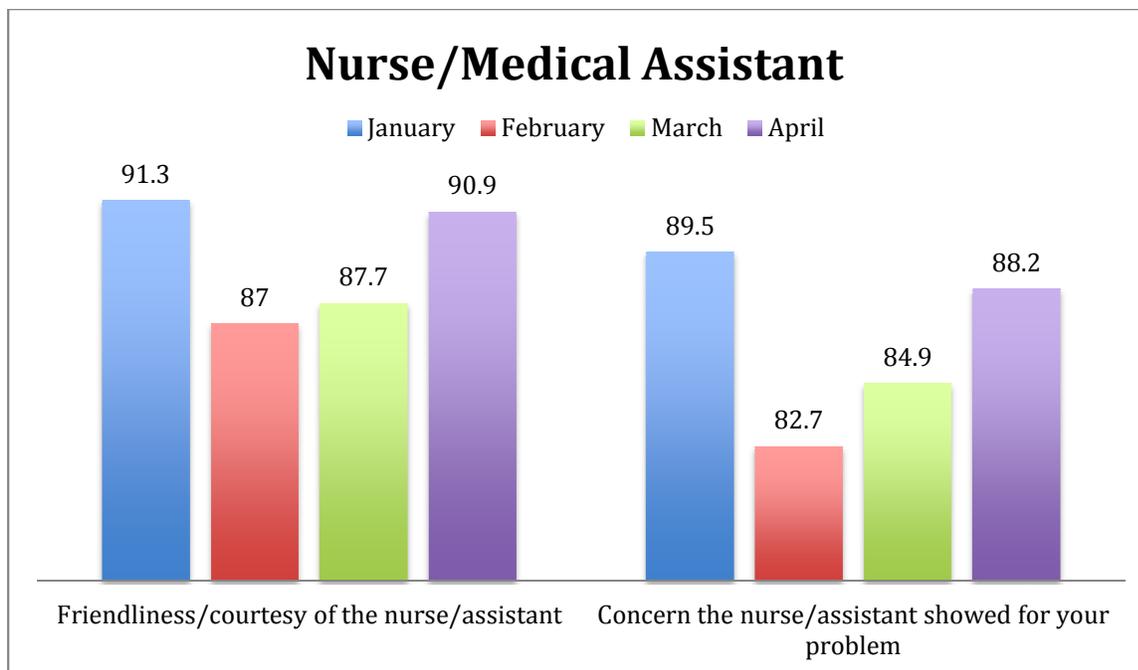


Figure 4. Nurse/Medical Assistant comparison in the Patient Center Medical Home; January through April of 2014.

The next section was the most detailed section with 11 questions for the respondent. The section is for the care provider (CP); and for this particular PCMH the only providers being evaluated are doctors (whether they are medical doctors (MD) or doctors of osteopathy (DO)). Therefore, the nurse practitioners are not included. The questions in this section include: the friendliness/courtesy of the care provider; explanations the care provider gave you about your problem or condition; concern the care provider showed for your questions or worries; care provider's effort to include you in decisions about your treatment; information other care provider gave you about follow up care; degree to which care provider talk with you using words you could understand; amount of time the care provider spent with you; your confidence in this provider; likelihood of your recommending this care provider to others and overall rating of the care provider.

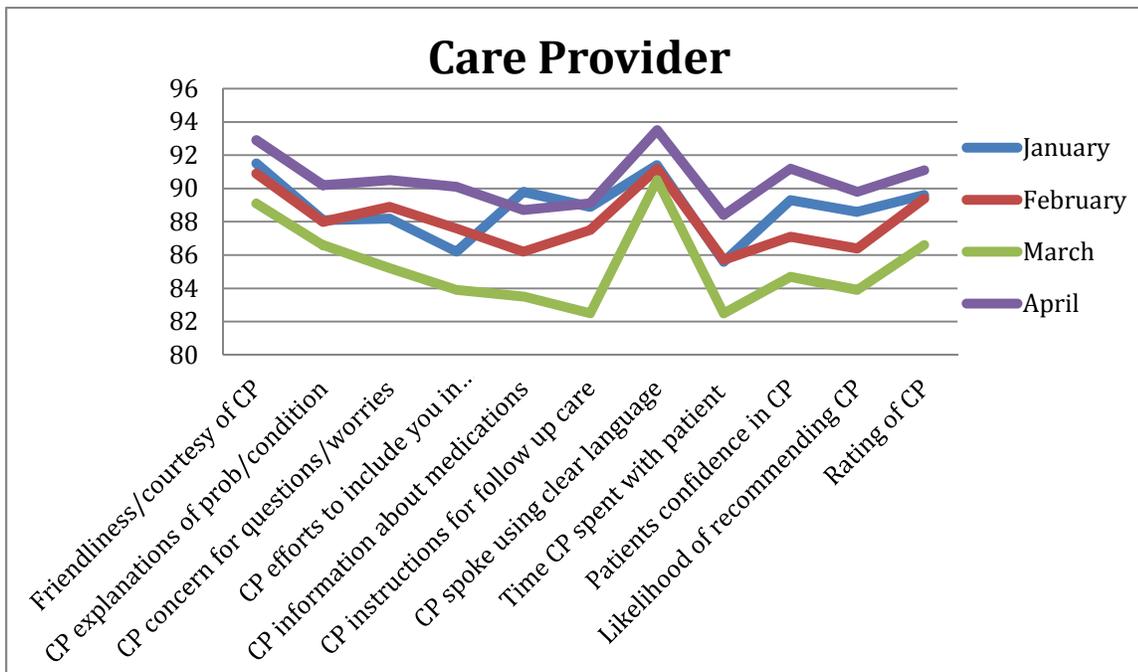


Figure 5. Care Providers in the Patient Center Medical Home; January through April of 2014.

The next section allows the respondent to reflect on any personal issues they may have had during their visit with the PCMH (figure 6). This allows them to interpret how well they believe the staff protected their safety, the staffs' sensitivity to their needs; the staffs' concern for patients' privacy; ease of obtaining a referral and cleanliness of the practice. The commentary in this section ranged from "excellent" to "I had to wait for a referral, and eventually had to leave without it. This was simply an issue of communication with the front desk staff. I think they forgot I was waiting there."

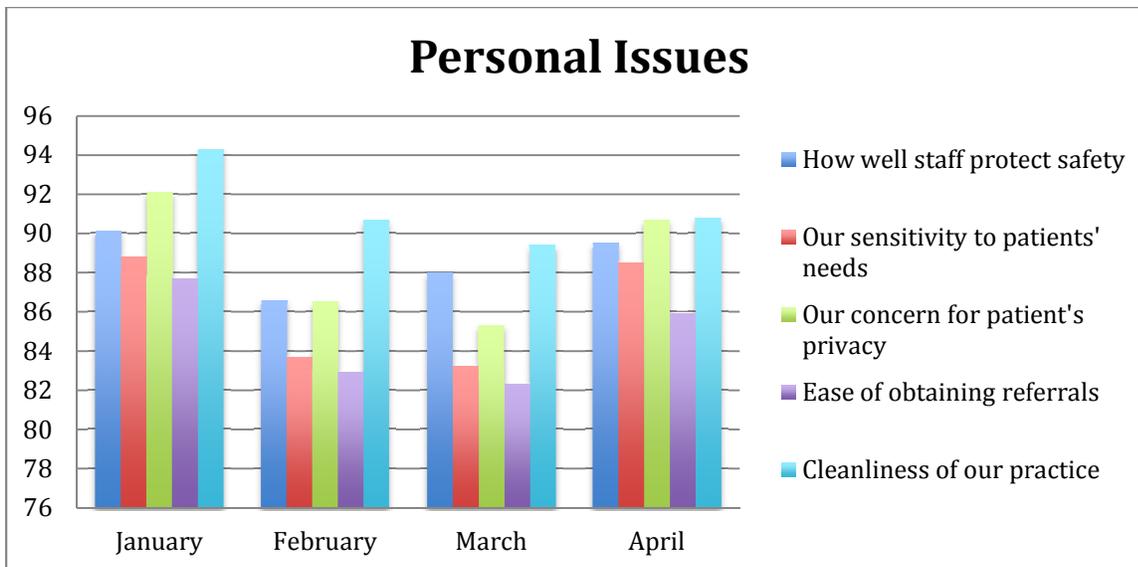


Figure 6. Personal Issues in the Patient Center Medical Home; January through April of 2014.

Finally, the last section of the questionnaire is the staff assessment (figure 7).

This sections touches on key aspects from majority of the sections that we just spoke about. This section asks the respondents to reflect on: how well the staff worked together to care for them; the likelihood of the respondent to recommend the practice to others; overall rating of care received during their visit and the response to concerns/complaints made during your visit.

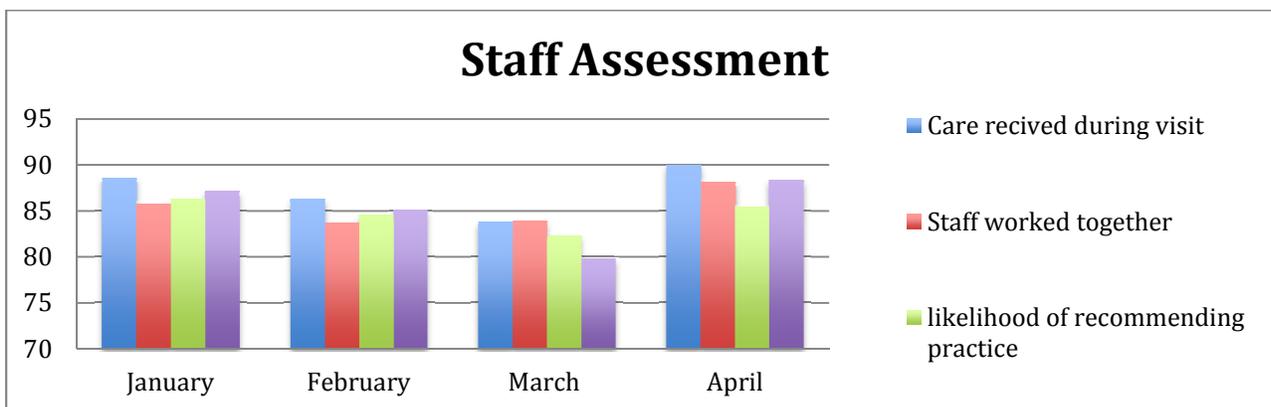


Figure 7. Overall Assessment in the Patient Center Medical Home; January through April of 2014.

Chapter Five: Data Analysis

The purpose of this study is to examine the impact patient center medical homes have on the patient experience. This was done primarily through focusing on the attitudes of patients on the quality of care they receive at their patient center medical home; the characteristics that are associated with positive variability in patient experience; and the factors that are in control of the PCMH that can be modified to improve patient experience.

The National Committee for Quality Assurance (NCQA) helps to identify the essential services that have to be provided so they can be declared as a PCMH. This also makes sure that the PCMH strengthen a long-term, coordinated care between physicians and their patients (Savage, Lauby and Burkard, 2013). They do this by broadly defining what creates a practice that declares them as a PCMH. According to the respondents many of the services alleged to be present in the PCMH facilities are not actually available or not adequate. Therefore, it can be argued that demand for PCMH has outpaced supply and resources in these areas. According to many of the respondents, the unmet needs for PCMH will continue to be present unless an investment is made in doctors to increase accessibility and in staff to make getting from step a to step b faster (example getting a referral).

Access to a PCMH center is seen as a basic right for anyone. It is very important and is seen as a major health and development factor for effective utilization in any community. The study has shown that the majority of the participants indicated that they had easy access to the PCMH centers in terms of getting to this one in terms of any form of transportation, which notably helped the access score. The study also

demonstrated that in terms of hours of operation, PHC facilities were open at convenient times. However, some respondents were concerned about the time they may have to wait to see certain providers and in some case their own primary care provider. The PCMH also received very low scores on being able to get through on the phone. This is concerning because if you were having an emergency or just needed a recommendation from your provider or your care team it may be very difficult for you to get through. This might create gaps in care.

The literature has emphasized the need for patients to go to their primary care physicians and to specialist instead of visiting hospitals frequently. This corresponds with the response of multiple respondents ties directly with every single section of the survey. However, moving through the visit is a major correspondent to this. It is essential for the patient experience for the patient to get in and get out while having all their concerns and issues addressed. It's like anything else; if you don't feel comfortable, important or feel like your needs weren't met, then the likelihood for you to return is directly impacted. This particular PCMH scored the lowest in the information about delays section. Therefore, this center seemed to have failed to meet their patients' expectations; the patients probably weren't told when their providers or the staff was running behind.

As indicated by responses of the patients, the subjects discussed and scored the reception staff, nurses and medical assistants very well. They evaluated them on how courteous and friendly they were. They also evaluated how well the nurse/medical assistant addressed their concerns and issues. The care providers also scored very well in every section. However, one section was very concerning-the care providers'

instruction on follow up and the time spent with care providers. This goes right back to what was expressed in the previous section; there is going to be a need for a push for more family medicine or even internal medicine providers. So, that the ones we do have don't become overwhelmed are overworked. This is likely to occur because of the push for patients to go to their primary care physicians instead of places like hospitals, urgent care centers, etc. With that being said we need to make sure these PCMH are staffed accordingly and have the proper resources. So, we can try to minimize patients feeling like the staff is uncaring and are not interested in them. If the PCMHs are staffed correctly the nurse or assistants only focus should be the patient that they are attending to. This ties right into the respondents' personal issues. Overall the respondents scored this medical home pretty high. However, the respondents gave the lowest scores to the process of being able to obtain referrals. If they aren't able to see the specialist and get the referrals they need then we will not be able to keep the patients out of emergency room and hospitals, or even get them diagnosed early enough to stop serious illness from occurring.

Chapter Six: Conclusion

The purpose of the primary care approach was adopted in order to promote accessibility and continuity of health care services. It is considered a positive intervention when it comes to preventive medicine; however, there are many other factors that contribute to an individual's well-being. This is where the patient center medical home becomes a major factor. The patient center medical home allows for primary care to be reinforced by having other strategies in order to fill in the gaps. That is why it is considered essential by the National Committee for Quality Assurance based on both its practical and socially acceptable means. This also makes it completely accessible to everyone in any community.

Previously, it was mentioned that a challenge of the PCMH may be the lack of primary care physicians and the lack of effective resources and hurdles of health education. However, from the data collected it seems as if in this particular PCMH the hardest part seems to be moving through the visit once the patient has already been attracted to the practice. This could simply be addressing the bottlenecks. Thus, it can be argued that in order to insure effective health service in PCMH make sure that the work flow is efficient, they are staffed correctly and everyone is working at the top of their scope. This is how the PCMH can be modified to improve patient experience.

The attitudes of the patients on the quality of care they received were always above 80%. Therefore, like every other service industry it is essential to keep the customer in mind and keeping them happy. It goes right along with the generic phrase; *the customer is always right*. This alone will keep the patient experience positive and the attitudes of the patients regarding their healthcare positive.

Therefore, PCMH is cost-effective and essential for both primary health care providers and patients. The adoption of PCMH could both enhance and support the current care provided in primary care provider offices. It allows patients and health care providers more resources and access to treatments in other areas of their life outside of healthcare. PCMH can eliminate barriers in healthcare such as homelessness, starvation, clothes, etc. This would ultimately decrease health disparities, and motivate efficiencies in the health care.

The study demonstrated that if health care providers and patients participate in an effective PCMH, they would be better equipped and more willing to address both their medical and social issues. However, this means that additional work needs to be done to comprehend the concerns and issues of the patients, which means that the patients have to feel comfortable enough with the staff to be able to open up with their concerns and issues. Thus, development strategy, including those correlated to ensuring appropriate planning of resources, as well as train and develop staff to improve the quality of PCMH services.

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