A Mixed- Methods Exploration of Hidden Access in Primary Care

Hadar Re'em

Kyle Shaak MPH
Lehigh Valley Health Network, Kyle.Shaak@lvhn.org

Akash Sheth
Lehigh Valley Health Network, Akash.Sheth@lvhn.org

Melanie B. Johnson MPA
Lehigh Valley Health Network, Melanie_B.Johnson@lvhn.org

Grant M. Greenberg M.D., M.H.S.A., M.A.
Lehigh Valley Health Network, grant.greenberg@lvhn.org

Published In/Presented At

Re'em, H., Shaak, K., Sheth, A., Johnson, M., Greenberg, G., (2018, 3, August) *A Mixed- Methods Exploration of Hidden Access in Primary Care.* Poster presented at LVHN Research Scholar Program Poster Session, Lehigh Valley Health Network, Allentown, PA.

A Mixed- Methods Exploration of Hidden Access in Primary Care

Hadar Re'em, Kyle Shaak, MPH, Akash Sheth, MS, Melanie Johnson, MPA, & Grant Greenberg, MD, MHSA, MA

Lehigh Valley Health Network, Allentown, Pennsylvania

Background

- Main attributes of primary care include quality of care, efficiency of care, and equity in health[1].
- The absence of these attributes may limit access and negatively impact the success of a practice and its patients' overall health.
- *Hidden Access*: the identification of population health opportunities by increasing capacity to meet demand, without sacrificing quality of care or patient satisfaction rates.
- **Purpose: How can we identify access improvement opportunities in LVPG (Lehigh Valley Physician Group) Family Medicine locations?**

Methods

Convergent Mixed Methods Design

Quantitative Data Collection:
- Retrieve Electronic Medical Record data
- Conduct Spearman Correlations & Quasi Poisson Regression models in SPSS

Qualitative Data Collection:
- Design & conduct clinician and staff interviews
- Observe practice workflow & utilization of staff

Merge data through analyses & proposal of recommendations

Results

- Contrary to physicians' perceptions, results of the Spearman correlation indicated that there was no correlation between continuity of care and patient satisfaction rates, ($rs(18) = .251$, $p = .286$).
- Additionally, results of Spearman correlations indicated that overall there was no correlation between continuity of care and 12 quality metrics, per provider and per practice.
- Results of the Quasi Poisson Regression model indicated:

Tables 1, 2

Diabetes & Hypertension Primary Diagnosis

Comparisons of Average Number of Visits

Practice and Controlled Status Comparisons	*Percent difference compared to baseline (Practice B)*
Practice A, controlled Diabetes	30.2%
Practice C, controlled Diabetes	19.3%
Practice C, uncontrolled Diabetes	40.1%
Practice C, controlled Hypertension	27.0%

Practice and Controlled Status Comparisons	*β*	*t*	*p**
Practice A, controlled Diabetes	0.26384	5.568	<.001*
Practice C, controlled Diabetes	0.17618	4.852	<.001*
Practice C, uncontrolled Diabetes	0.16777	2.069	0.04*
Practice C, controlled Hypertension	0.23911	10.990	<.001*

Results

Interviews with providers revealed high variability in opinions on the optimal number of visits for patients with certain controlled or uncontrolled chronic illnesses.

"I would see a patient (with Chronic Obstructive Pulmonary Disease) weekly until they are controlled." – Provider from Practice C

As opposed to all other providers interviewed, who answered 2 to 4 times a year for the same type of patient

Recommendations

- Standardization and education of coding, billing, and diagnosis documentation within LVHN in a manner that has core components that are implemented with fidelity, while allowing for adaptation to unique practice culture and characteristics
- Maximize roles and capacity of non-physician clinical staff members
- Carve out time slots for same-day appointments each day
- Weekly and monthly team meetings to discuss panel management in a proactive manner- avoiding unnecessary follow ups- and to ensure continued quality of care

References:

1 Kringos DS, Boerma WG, Hutchinson A, et al. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Serv Res, 2010;10:65.

Lehigh Valley Health Network

LVHN.org