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A Closer Examination of the Patient Experience in the Ambulatory Space: A Retrospective Qualitative Comparison of Specialty Care to Primary Care Experiences

Zahi R. Jurdi, MHSA¹, James E. Harris Jr., MD¹, Joseph F. Crosby Jr., PhD, RPh², and Jillian B. Harvey, PhD, MPH³

Abstract

With the advent of consumerism in one of the most complex and fragmented industries in the United States, the healthcare space now has a collective interest to further understand its consumers and help to shape their experiences. In this qualitative research study, we explore the key patient experience impressions responsible for driving quality. Differences between primary care patient perspectives and specialty care patient perspectives were analyzed using a mixed methods design in high, median and low quality performing practices. We found that primary care patients highly value (a) provider listening, (b) time spent with provider, and (c) consistent and effective coordination of care (i.e. provider handoffs, referrals, prescription refills, etc.). Specialty care patients were found to highly value (a) provider clinical skill acumen and outcomes, (b) being kept informed with timely updates and care instructions, and (c) a stress and pain-free experience. Both patient types also highly value a patient- and family- centered care team approach. We did find a direct association between patient experience quantitative scores and patient comments ratings. We conclude that differing patient types attach greater value to different elements of their health care experiences.

Keywords

patient experience, ambulatory, qualitative, primary care, specialty care, mixed methods

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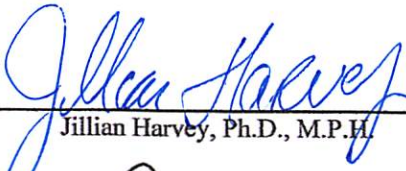
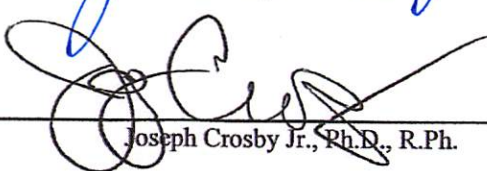
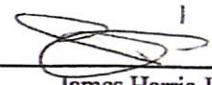
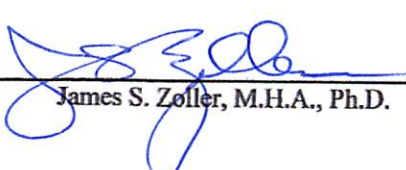
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A CLOSER EXAMINATION OF THE PATIENT EXPERIENCE IN THE AMBULATORY
SPACE: A RETROSPECTIVE QUALITATIVE COMPARISON OF PRIMARY CARE TO
SPECIALTY CARE EXPERIENCES

BY

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The current dynamics of the healthcare industry have set the marker for what some would argue to be the most controversial political and healthcare landscape to date. Matters such as repeal and replace the Patient Protection and Affordable Care Act (ACA), electronic health record (EHR) mandates, shifts in reimbursement models from volume to value and health system integration and consolidation are some of the chief priorities (Berwick, 2016). Berwick (2016) notes the importance of social goals such as overall better healthcare, increased health status and decreased costs. However, the two previous eras of medicine defined by professional prerogatives and enhanced inspection and control has proven to be a blockade to attaining such social goals. Berwick (2016) has offered up nine key changes, which he has designated era 3 for medicine and healthcare.

As it relates to this paper, the new era of medicine must consider the patient perspective, not only the numbers. Berwick (2016) refers to the patient perspective as step eight in his proposed change era: hear the voices of the people served. “Clinicians, and those who train them, should learn how to ask less, what is the matter with you? And more, what matters to you?” (Berwick, 2016, p. 1330).

Assessing consumer experiences in nearly all industries has become the standard. With the advent of consumerism in one of the most complex and fragmented industries in the United States, the healthcare space now has a collective interest to further understand its consumers and help to shape their experiences. This is evidenced by the Quadruple Aim, which takes an integrated approach to optimize health system performance (IHI, 2017). Improving the patient experience is one of the four key factors of the Quadruple Aim (i.e. improve the patient experience, drive population health, reduce healthcare expenditures and mitigate clinician burnout) (Bodenheimer & Sinsky, 2014).

Healthcare organizations continue to experience a shift to the new paradigm of service and patient experience. Some would argue that price and product appear to be close to parity and that to gain competitive advantage, healthcare organizations must truly focus on the patient experience (Ford & Fottler, 2000). This does not suggest that other factors such as patient safety, fiscal stability, operational efficiency, regulatory compliance and clinical outcomes should not hold great priority as well.

The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS®) is the standard mechanism for collecting and reporting information about patient experiences in the ambulatory setting in the United States (Quigley, Martino, Brown & Hays, 2013). Prior to the introduction of CAHPS, an abundance of existing health plan consumer surveys were based on the Group Health Association of America (GHAA) consumer survey instrument (Lake, Kvam & Gold, 2005). GHAA arose from research such as the Health Insurance Experiment and Medical Outcomes Study (Gold & Wooldridge, 1995). As a result, an assortment of surveys existed in the marketplace leading to inconsistencies in measurement methodologies and benchmarks. There was a need for a single standard of measuring and reporting on consumers' experiences with their respective health plans.

Consumer assessments of their experiences are now routinely collected and reported to the Centers for Medicare and Medicaid Services (CMS). Under the ACA, those organizations wishing to participate in the CAHPS survey are mandated to collect on and report patient experience data resulting in potential enhancements to organizational compensation rates for meeting particular patient experience quality targets. Patient-centeredness can be considered a quality dimension in and of itself, therefore improving the overall patient experience is fundamental for improving healthcare quality (Berwick, 2009; IOM, 2001). This is in line with

the reimbursement model shift from volume-based to value-based reimbursement. CMS provides explicit incentives for improving the patient experience via value-based purchasing and provider CG CAHPS scores are quality outcomes linked to ACO reimbursement (CMS, 2015b).

During fiscal year 2015, hospitals were provided the opportunity to either gain or lose up to 1.5% of their Medicare payments (Harting, 2014). As of fiscal year 2017, CMS increased that Medicare reimbursement rate to 2% (Harting, 2014). In an effort to drive quality, the CMS value-based purchasing (VBP) program withholds and/or redistributes care reimbursement to organizations performing above average (Kazley, Ford, Diana & Menachemi, 2015). Under the CMS VBP arrangement, patient experience measures justify thirty percent of the total score used to select particular hospitals which qualify for re-distributions of the shared withholdings (Keckley, Coughin, & Gupta, 2012; CMS, 2015a). This linkage illustrates the business case between consumer experiences and quality outcomes.

The following section will explain the key limitation in the current literature surrounding a clear understanding of the patient experience and puts forth a proposal to better understand key patient perceptions.

Problem Statement

All ambulatory practices obtain feedback on the patient experience, however the key patient impressions responsible for driving the numerical CG CAHPS data (quantitative percentiles) between primary and specialty care service lines in both high and low performing sites, are unknown. There appears to be a need for a qualitative approach to better understand how and why patients form particular impressions across service lines in the ambulatory environment. The purpose of this study is to examine patients' perceptions about care experiences across

different ambulatory practice sizes, provider types, and in high and low levels of provider quality performance.

New Contribution

Most practices examine the CG CAHPS data through a quantitative lens to search for trends and/or associations between survey questions and overall provider rating and willingness to recommend a provider. Furthermore, the communication domain of questions has been a clear focus of the current literature. Based on this historical quantitative focus, there exists a gap between qualitative research efforts to drive quality improvement (QI) in the patient experience sector. As such, there exists a need to further examine unstructured key patient statements from the CG CAHPS survey to explore how and why patient impressions are formed between primary care and specialty care patients.

Current Literature

Current literature uses both quantitative and qualitative approaches to highlight the elements critical to patient-provider communication and overall patient experiences. Data and information gleaned from CG CAHPS surveys has and continues to result in a linkage to improved patient outcomes (Anhang Price et al., 2014). Since its inception in 1995, the CAHPS project has served as a chief mechanism for the development of scientifically sound measures of consumer perspectives surrounding access to care and quality of care levels (Lake, Kvam & Gold, 2005). Anhang Price et al. (2014) note “research indicates that better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes, better clinical outcomes, better patient safety within hospitals, and less health care utilization” (p.

522). Patient reports indicate that doctor communication is the strongest predictor of overall provider ratings for both primary care (Hargraves, Hays & Cleary, 2003; Tallman et al., 2007; Wilkins, Elliott, Richardson, Lozano & Mangione-Smith, 2011) and specialty care (Ruiz-Moral, Perez Rodriguez, Perula de Torres & de la Torre, 2006; Sofaer, Crofton, Goldstein, Hoy & Crabb, 2005). The *care team showing respect for the patient* has been consistently evidenced as the most important communication element across all specialties. Ruiz-Moral, Perez Rodriguez, Perula de Torres & de la Torre (2006) indicate that the majority of specialists do not leverage a patient- and family- centered approach, rather they use a managerial style. Such an approach fails to adequately explore patient emotions, expectations and psychosocial aspects (Ruiz-Moral, Perez Rodriguez, Perula de Torres & de la Torre, 2006). In stark contrast, Chaitoff et al. (2017) found particular specialty providers to exhibit higher empathy scores when using internal medicine as the point of reference. Additionally, organizations have not been successful with involving patients and learning from their experiences (Davies & Cleary, 2005; Groene et al., 2009; Wensing, Vingerhoets, & Grol, 2003).

An exploratory qualitative approach such as an archival analysis of CG CAHPS patient comments may provide for a more fruitful understanding of patient perceptions and experiences across primary care and specialty care settings. Luxford, Safran and Delbanco (2011) reported that patient narratives act as catalysts for change and that patient stories from both qualitative surveys and individual patient journals provide invaluable insights not typically captured in the quantitative world. Shi (2008) notes that the primary relevance of qualitative research centers on exploratory discovery and inductive reasoning. Qualitative research is quite relevant in relation to the objective of exploring attitudes, feelings, complete events, phenomena and factors associated with changing processes (Shi, 2008). Such objectives may draw parallels with patient

comments from the CG CAHPS surveys as qualitative techniques center more around observations and analyses that are less numerically measurable (Shi, 2008). Types of qualitative research may include participant observation, in-depth interviews and case studies (Shi, 2008). Although CG CAHPS comments may not fall directly into one of the three aforementioned categories, such data is still considered to be qualitative as it provides information about a naturally occurring phenomena, how and why patients experienced their healthcare encounter in the manner in which they did.

The gap in the current literature surrounding the use of qualitative research to drive QI in the patient experience space has heightened the need to further investigate key patient perceptions across primary care and specialty care ambulatory practice settings. The following section will review the design and method of qualitative data collection and analysis in this study.

Methods

The purpose of this study was to examine patient perceptions about care experiences across different ambulatory practice sizes, provider types, and in high and low levels of provider quality performance. We use a mixed-method study design, in that quantitative data was used to select the qualitative data samples. Feters, Curry and Creswell (2013) note that qualitative data may be used to gauge the validity of quantitative results, while quantitative data may be used to help generate or select the qualitative sample or explain the results from qualitative data. In our study, both quantitative and qualitative data were collected concurrently, a basic design that has been coined, *convergent design* (Feters, Curry & Creswell 2013). In a *convergent design*, initial quantitative findings may have the ability to influence the nature of the qualitative data being

collected (Fetters, Curry & Creswell 2013). This exploratory qualitative study used a general inductive approach to compare patient written or typed comments across the differing provider contexts.

Operational Definitions

Site: Defined by physical brick and mortar location. One site may have multiple practices.

Practice: Defined as the clinic within a site. A practice/clinic may be part of a larger site or may stand alone.

Primary care physician: “A primary care physician is a specialist in Family Medicine, Internal Medicine or Pediatrics who provides definitive care to the undifferentiated patient at the point of first contact, and takes continuing responsibility for providing the patient's comprehensive care” (AAFP, 2017, para 8-9). Such care may encompass chronic, preventive and/or acute care in both the inpatient and outpatient setting. Primary care practice is typically characterized by a personal primary care physician who may serve as the main entry point for a considerable portion of the patient's medical and health care needs (AAFP, 2017).

Specialty care physician: “A specialist doctor is a physician whose practice is limited to a particular branch of medicine or surgery. This industry includes establishments or health practitioners with a doctor of medicine or doctor of osteopathy degree. These individuals primarily practice specialized medicine, such as anesthesiology; oncology and ophthalmology; or surgery. This industry does not include primary care physicians or mental health specialists” (IBIS World, 2017, para 1).

Full-time equivalent (FTE): “FTE means full-time equivalency for the purposes of a work year. FTE is primarily used when talking about staffing and hiring. For example, if you need 1 FTE

that means you need the equivalent of one full-time position. (That might be *two* people, each working half a year)” (HEIT Management, 2017, para 1).

Study Setting

The medical group practice aligned with a large academic health system located in the mid-Atlantic region was identified and selected for this study. During the time of the study, the medical group comprised 36 brick and mortar ambulatory sites serving patients and their families. Several of the larger sites contain multiple clinical service lines or divisions and are considered separate practices within a site. The medical group had 54 practices, inclusive of both primary care and specialty care during the time of this study. Although some of the medical group practices were considered multispecialty and had more than one clinical service line, only single specialty practices met the inclusion criteria and will be presented in the sample section.

Data Set Description

Three items from the CG CAHPS survey were examined in this study. [1] Most important to the objective of this study, CG CAHPS surveys include a voluntary open text field to entertain typed or hand-written patient comments (e-mail survey vs. mailed survey). This unstructured section of key patient statements allows for enhanced qualitative and exploratory data capture and is the focus of this paper. [2] We utilize the likelihood of recommending the practice to stratify the practice into low, median, and high quality. Finally, [3] we examine the CG CAHPS survey comments to compare the percentage of positive, negative, neutral or mixed comments across primary care and specialty practices. Survey comments are typically categorized via *sentiment analysis*, in which key statements represent positive or negative sentiment. A healthcare centric

natural language processing (NLP) engine identifies key sentiments and survey comments are then categorized into domains (Press Ganey, 2018). Sentiment analysis centers on NLP software that has the ability to analyze linguistic relationships and connections amongst words. It also has the ability to analyze syntax or the arrangement of words and context of phrases (Siegrist Jr. & Madden, 2011). In addition to searching for key words used to categorize comments, sentiment analysis rates the actual expressed sentiment as positive or negative on a ranging scale. Key phrases such as *extremely*, *horribly* or *very* can increase the intensity of such ratings (Siegrist Jr. & Madden, 2011).

Sample

Study researchers selected a purposeful stratified sampling frame to examine patient experience comments across differing provider contexts inclusive of family practice, general internal medicine, combined internal medicine-pediatrics (med peds), general surgery, cardiac surgery, orthopedic surgery and neurology. Provider organizations were selected, so as to try and assure a mix of patient respondents experiencing a variety of contexts that could impact perceptions including practice size, quality of care received, and specialty or primary care.

To categorize practices as high, median and low patient experience quality, we examined Item #23 in the CG CAHPS survey. This item states, “*Would you recommend this provider’s office to your family and friends?*” The metric is calculated as the percentage of patients who respond “*yes, definitely.*” “*Yes, definitely*” is considered top-box. Other answer options are “*yes, somewhat*” and “*no.*” Quantitative percentile rankings were used to identify high, median and low performing practices using the CG CAHPS likelihood to definitely recommend a provider

office survey item percentile score. A total of 12 practices were identified as the study population.

Primary Care Sample

During FY17, the 50th percentile for likelihood to definitely recommend a provider office among participating ambulatory practices across the United States was 91.7% (U.S. DHHS, n.d.). This means, that if a practice earns a top-box score above 91.7% during FY17, the respective practice is scoring higher than 50 percent of the competing ambulatory practices across the country.

Practice selection was based on the likelihood to recommend survey item with only the top-box scores receiving credit. The two highest scoring primary care practices, the two-median scoring primary care practices and the two lowest scoring primary care practices were selected. Median scoring practices are those closest to the 50th percentile industry benchmark for likelihood to definitely recommend during the same time period of the study.

Table 1. Primary Care Sample Description

	Total returned survey count – likelihood to <u>definitely</u> recommend	US 50th percentile – likelihood to <u>definitely</u> recommend	US 75th percentile – likelihood to <u>definitely</u> recommend	Practice likelihood to <u>definitely</u> recommend score	Clinical Division	# of FTE providers (MDs, DOs, PAs, NPs)	Urban, rural, suburban setting
High scoring primary care practice A	1,040	91.70%	94.70%	93.42%	Family Practice	4.70 FTEs	Suburban
High scoring primary care practice B	877	91.70%	94.70%	92.15%	General internal medicine	1.88 FTEs	Urban
Median scoring primary care practice A	1,560	91.70%	94.70%	92.00%	Family Practice	5.65 FTEs	Suburban
Median scoring primary care practice B	1,836	91.70%	94.70%	91.25%	Family practice	6.70 FTEs	Rural

Low scoring primary care practice A	1,504	91.70%	94.70%	77.76%	General internal medicine	4.74 FTEs	Suburban
Low scoring primary care practice B	111	91.70%	94.70%	75.31%	Med Peds	7.75 FTEs	Urban

Practices with less than 1.0 FTE provider during FY17 were excluded from the study as the patient comments could be identifiable. Although the medical group in this study considers both service lines to be that of a primary care focus, OB-GYN and pediatrics service lines were excluded from the primary care sample selection due to lack of comparability across several contexts (e.g. care setting, patient population, appointment frequency, etc.). Lastly, urgent care services were not included in the primary care sample selection and analysis due to lack of equitable comparability (practice setting, case-mix, etc.).

Specialty Care Sample

The two highest scoring specialty care practices, the two median scoring specialty care practices and the two lowest scoring specialty care practices were selected using the same criteria as the primary care practices.

Table 2. Specialty Care Sample Description

	Total returned survey count - likelihood to <u>definitely</u> recommend	US 50 th percentile – likelihood to <u>definitely</u> recommend	US 75 th percentile – likelihood to <u>definitely</u> recommend	Practice likelihood to <u>definitely</u> recommend score	Clinical Division	# of FTE providers (MDs, DOs, PAs, NPs)	Urban, rural, suburban setting
High scoring specialty care practice A	150	91.70%	94.70%	98.20%	General Surgery	2.39 FTEs	Suburban
High scoring specialty care practice B	54	91.70%	94.70%	96.75%	General Surgery	1.94 FTEs	Suburban
Median scoring	294	91.70%	94.70%	93.07%	Cardiac Surgery	1.79 FTEs	Suburban

specialty care practice A							
Median scoring specialty care practice B	586	91.70%	94.70%	92.58%	General Surgery	6.54 FTEs	Suburban
Low scoring specialty care practice A	472	91.70%	94.70%	86.92%	Orthopedic Surgery	4.04 FTEs	Suburban
Low scoring specialty care practice B	135	91.70%	94.70%	85.20%	Neurology	2.10 FTEs	Suburban

Provider Quality

All percentile rankings are those of top-box. The top-box answer selection for the likelihood to recommend is bolded in table 3:

Table 3. Top Box Score Selection

Question	Top Box Score Bolded
Would you recommend this provider's office to your family and friends?	Yes, definitely Yes, somewhat No

All percentile rankings are benchmarked against the 75th percentile for top-box scores only as provided for each of the question categories, overall provider rating and likelihood to recommend the providers office.

The research questions to be explored in this study are presented in the next section.

Analytic Strategy and Research Questions

Thomas (2006) notes the evident void in knowledge about effective strategies used for efficient and conceivable analyses of qualitative data. "The general inductive approach provides an easily used and systematic set of procedures for analyzing qualitative data that can produce reliable and

valid findings. It does provide a simple, straightforward approach for deriving findings in the context of focused evaluation questions” (Thomas, 2006, p. 237). Inductive analysis has been described as a set of approaches that use detailed accounts of raw data to develop concepts or themes based on an evaluator’s interpretations made from the raw data (Thomas, 2006). This description parallels that of Strauss and Corbin (1998) who define inductive analysis as research that begins with a particular area of exploration allowing for potential theory to surface from the data. Scriven (1991, p. 56) describes the inductive approach as “goal-free” where by evaluators aim to determine actual program effects, not solely planned effects.

There were four questions pertaining to this study:

- 1.) Is there is a difference in patient perceptions between low and high CG CAHPS percentile scores in primary and specialty care practices?
- 2.) What matters most to primary care and specialty care patients during their care experience?
- 3.) Are there differing levels of patient appreciation for a primary care provider versus a specialty care provider?
- 4.) Do specialty care providers communicate differently than primary care providers?

The primary analytic strategy of this study was to determine what are the most prevalent or core meanings that are palpable in the key patient statements relevant to the research questions (Thomas, 2006).

Patient comments from the 12 practices, six primary care and six specialty care, were reviewed and analyzed using the general inductive approach (Thomas, 2006). Coding was carried out resulting in core meanings or broad generalizations from the specific patient comments. Two researchers independently read and initially coded the data resulting in a total of

20 codes. After discussion and mutual review of the data, three initial codes were merged together and another code emerged. Lastly, two codes were merged again and two more codes emerged resulting in a total of 18 codes (table 5). The coding process was repeated until no new themes surfaced. The evaluators identified 3,082 patient comments across the study population, however saturation was reached upon completing a review and analysis of 1,852 patient comments across the 12 selected practices. The two chief evaluators came to an agreement on the final coding scheme through discussion. Thematic categories were quality checked by the senior evaluator to ensure accuracy and consistency in the coding process and emerging themes. Microsoft excel was used to manage and query both the raw and coded data.

Table 5. Code Book

Sub-codes	Description	Code
Praise/Appreciation		
1. Praise/appreciate listening	<ul style="list-style-type: none"> ➤ Statements related to intently listening to the patient/family member (e.g. provider listens to what I have to say, my concerns/comments are considered in my treatment plan or my family members' treatment plan) 	L
2. Praise/appreciate taking time	<ul style="list-style-type: none"> ➤ Statements related to provider/staff taking the time to listen to the patient/family member and answer questions ➤ Statements related to the patient/family member not feeling rushed 	TT
3. Praise/appreciate care instructions	<ul style="list-style-type: none"> ➤ Statements related to explaining/articulating care options and treatment plan in a way that the patient/family understands 	CI
4. Praise/appreciate clinical knowledge/outcomes	<ul style="list-style-type: none"> ➤ Statements related to clinical skill acumen and quality outcomes (e.g. have complete confidence in my provider, well qualified, knows his/her stuff, etc.) 	CK
5. Praise/appreciate patient-centeredness	<ul style="list-style-type: none"> ➤ Actions related to treating patients/family members in a patient- and family- centered manner resulting in a mutually beneficial partnership between the provider/care team and the patient/family (i.e., personable, caring, mindfulness, practicing presence, service, professionalism, bed-side manner, kindness, friendliness, politeness, eye contact, workstation use/patient engagement, considerate, language interpretation/translation, etc.) 	PC

6. Praise/appreciate courtesy	➤ Statements related to courtesy and respect either in-person, electronically or via telephone (e.g., makes me feel valued, makes me feel understood, etc.)	C
7. Praise/appreciate thoroughness	➤ Statements related to the detail of the outlined treatment plan(s), alternative treatment options, etc.	T
8. Praise/appreciate overall	➤ General statements related to appreciation of the provider/staff (e.g., best doctor ever, such great staff, etc.)	O
9. Praise/appreciate generic	➤ General statements related to generic appreciation (e.g. happy with my care, great office, etc.)	G
10. Praise/appreciate stress/pain free experience	➤ Statements related to easing anxiety and pain (i.e. made me feel comfortable and relaxed)	SP
11. Praise/appreciate being kept informed	➤ Statements related to timely updates related to care plan (in clinic setting, in hospital, at home, on phone, etc.)	KI
12. Praise/appreciate parking access, commute	➤ Statements related to easy vehicle parking access, campus navigation, parking expenses, physical proximity to home, etc.	PK
Care Coordination		
13. Care coordination of medical history	➤ Statements related to familiarity with patients' history (e.g. clinical, social, medical, surgical, etc.)	CCMH
14. Care coordination to enhance continuity of care	➤ Statements related to handoffs between appointments, providers and staff ➤ Statements related to coordination of referrals and prescription refills	CCCC
Timely Care		
15. Timely care - limited wait time	➤ Statements related to little or no wait time (efficiency) during appointment/clinic experience (e.g. check-in, check-out, waiting in exam room, etc.)	TCWT
16. Timely care - access	➤ Statements related to accessing a team member (i.e. telephone, MyChart, etc.) ➤ Obtaining an appointment for self or family member in a timely manner and when is convenient for the patient/family (e.g. able to get me in for an appointment the next day, etc.)	TCA
Communication		
17. Communication follow-up (i.e. lab results f/u, clinical questions, etc.)	➤ Statements related to timely f/u communication related to care (e.g., clinical outcomes, test results f/u, MyChart, etc.)	CFU
18. Communication of timely updates	➤ Statements related to timely communication of updates (e.g., appointment changes, confirming scheduled appointments, questions, etc.)	CTU

Outcome of Analysis

The key outcome of the analysis was that of thematic categories most relevant to the research questions in this study and will be presented in the results section (Thomas, 2006).

Results and Presentation of Findings

The FY17 average return rate across all of the medical group practice was 17.5%, while the national response rate is 19.3% (R. Meeks, personal communication, August 23, 2017; October 20, 2017). The analysis included a total of 1,852 patient comments across the 12 ambulatory practices. In general, we found that those practices with higher overall percentile scores on likelihood to definitely recommend (top-box score), had greater proportions of positively rated patient comments (table 6 and table 7). Positive comments typically have a positive sentiment, while negative comments have an overall negative sentiment. Mixed comments contain both a positive and negative sentiment and neutral comments do not contain either a positive or negative sentiment.

Table 6. Primary Care Patient Comments Ratings

	Clinical Division	# of FTE providers (MDs, DOs, PAs, NPs)	Negative Comments % (n)	Positive Comments % (n)	Mixed Comments % (n)	Neutral Comments % (n)
High scoring primary care practice A	Family Practice	4.70 FTEs	8.40% (30)	70.31% (251)	12.89% (46)	8.40% (30)
High scoring primary care practice B	General internal medicine	1.88 FTEs	14.45% (51)	63.74% (225)	15.58% (55)	6.23% (22)
Median scoring primary care practice A	Family Practice	5.65 FTEs	12.06% (68)	66.84% (377)	12.23% (69)	8.87% (50)
Median scoring	Family practice	6.70 FTEs	13.34% (79)	61.99% (367)	16.72% (99)	7.94% (47)

primary care practice B						
Low scoring primary care practice A	General internal medicine	4.74 FTEs	17.21% (90)	53.15% (278)	22.18% (116)	7.46% (39)
Low scoring primary care practice B	Med Peds	7.75 FTEs	17.14% (6)	74.29% (26)	-	8.57% (3)

Table 7. Specialty Care Patient Comments Ratings

	Clinical Division	# of FTE providers (MDs, DOs, PAs, NPs)	Negative Comments % (n)	Positive Comments % (n)	Mixed Comments % (n)	Neutral Comments % (n)
High scoring specialty care practice A	General Surgery	2.39 FTEs	3.77% (2)	79.25% (42)	5.66% (3)	11.32% (6)
High scoring specialty care practice B	General Surgery	1.94 FTEs	17.39% (4)	52.17% (12)	4.35% (1)	26.09% (6)
Median scoring specialty care practice A	Cardiac Surgery	1.79 FTEs	9.23% (12)	66.92% (87)	6.92% (9)	16.92% (22)
Median scoring specialty care practice B	General Surgery	6.54 FTEs	13.70% (30)	64.38% (141)	10.05% (22)	11.87% (26)
Low scoring specialty care practice A	Orthopedic Surgery	4.04 FTEs	16.67% (30)	55.00% (99)	14.44% (26)	13.89% (25)
Low scoring specialty care practice B	Neurology	2.10 FTEs	35.85% (19)	33.96% (18)	18.87% (10)	11.32% (6)

Table 8 provides examples of actual patient commentary.

Table 8. Actual Survey Comment Examples and Ratings

Negative	Positive	Mixed	Neutral
<i>The nursing staff that brought me back to my room was very rude. She never greeted me with a smile or even a hello. The</i>	<i>Dr. [name] is an excellent provider. The office staff are great. They always greet you with a smile and</i>	<i>Care was excellent, both Dr. [name] and her assistant couldn't have been better. The receptionist though, was</i>	<i>"Results on MyChart [electronic medical record patient portal]."</i>

<i>whole [way] to the exam room she did not utter one word. The only time she spoke to me was to ask me about my menstrual cycle and then again to give me my flu shot.</i>	<i>they always remember your name.</i>	<i>very blasé, far more concerned with staring at her computer than the people waiting to check in (which took 15 minutes, when it should have taken 1 minute.)</i>	
<i>On orders for breast MRI, someone wrote L for left breast when the cancer diagnosis was for the R right breast! I had to go back to the doctor's office from the radiologist who found the discrepancy, to get the order changed!</i>	<i>I have been a patient of Dr. [name] for over 25 years. He has performed 4 surgeries and multiple breast operations. He is highly skilled, compassionate and knowledgeable. He has always taken time to thoroughly communicate with me regarding each medical problem and surgery. He has always run a very professional office as well. Dr. [name] is simply the best!</i>	<i>I continue to be very well satisfied with the Dr [name] and the staff with which I interact in the [practice name] office. Recently, the reception area staff was very helpful in dealing with some issues regarding referrals. However, I would like to comment that the "centralized" appointment and phone system which [organization] has implemented, has not been a successful idea. I'm sure some IT person won an award for the cost savings, but it isn't patient friendly.</i>	<i>above questions NA</i>

Primary care patient comments were typically longer and more comprehensive than the specialty care patient comments. Primary care patient comments also numbered much higher than that of specialty care patient comments. The elevated volume of primary care patient comments may be attributed to the fact that primary care providers have standing patient panels, unlike common specialties in this study (i.e. general surgery, cardiac surgery, orthopedic surgery and neurology). Furthermore, more primary care patient encounters took place in FY17 than specialty care patient encounters in this study.

Next, we identified six key thematic categories.

Primary Care and Specialty Care Patients Value Different Elements of the Care Process

As it relates to our first research question, we found the patient perceptions do differ between low and high scoring practices on the, *would you recommend this provider's office* question. As previously noted in tables 6 and 7, in general, those practices with higher quantitative scores across both primary care and specialty care practices on likelihood to definitely recommend a provider's office had greater proportions of positively rated comments. Patient perceptions include what patients recognize, understand and remember. Perceptions differ based on individual experiences and may include beliefs, values, and cultural background (The Beryl Institute, 2017).

Next, and of the most significant findings of this study, different elements of a healthcare encounter may hold greater importance to patients across the primary care space and the specialty care space. Table 9 presents our findings related to the second research question, what matters most to primary care and specialty care patients during their outpatient care experience:

Table 9. Thematic Categories Indicating Most Important Elements of the Health Encounter in Descending Order

Primary Care Elements	Specialty Care Elements
<ol style="list-style-type: none"> 1. Provider taking time with me matters (appointment slot length, patient panel size) 2. Provider listening to me matters 3. Coordination of care/continuity of care and having a provider who knows me (clinical history and personally) <ol style="list-style-type: none"> a. During transition from one provider to another or when regular provider is not available b. During handoffs between appointments, providers and staff <ol style="list-style-type: none"> i. Statements related to coordination of referrals and prescription refills 4. Patient-centered provider and care team <ol style="list-style-type: none"> a. Appreciate professional, caring and compassionate providers/staff 5. Truly appreciate the use of MyChart for efficient communication (e.g. care instructions, lab results, being kept informed, appointments, etc.) 	<ol style="list-style-type: none"> 1. Appreciate clinical knowledge of provider and care team (i.e. <i>have confidence in my doctor, clinical skills, she saved my life, I can walk again, got my life back again, etc.</i>) <ol style="list-style-type: none"> a. Appreciate clinical care outcomes 2. Being kept informed and care instructions <ol style="list-style-type: none"> a. Appreciate thoroughness of provider explained care plan, test results, etc. 3. Being made to feel stress and pain-free <ol style="list-style-type: none"> a. Relaxed and comforted 4. Patient-centered provider and care team <ol style="list-style-type: none"> a. Appreciate professional, caring and compassionate providers and staff 5. Provider taking time with me matters (listening to my concerns or where I am feeling pain) 6. Accurate referral from PCP to correct specialist is important 7. Accurate referral to another specialist is important

<p>6. Short wait-times matter (have long waits)</p> <p>7. Expedient appointments are important (i.e. she got me in the next day or it seems to be a challenge in scheduling to see a doctor)</p> <p>8. Accurate coordination of referrals to specialists are important</p>	<p>8. Easy scheduling and coordination of specialty procedure matters</p> <p>9. Access to specialists in orthopedic surgery and neurology matters (up to 6 months)</p>
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Key Primary Care Themes I and II

The two most common themes noted by the researchers in the primary care sample included *provider taking time with me* and *provider listening to me*. Patient comments cited the importance of their primary care provider spending time with them, not feeling rushed, and listening to all of their healthcare concerns:

“I have always been 100% satisfied with the [organization name] practice. Excellent, treatment, care & attentiveness are the norm every time I got there. Everyone at the front desk, the nurse assistant to Dr. [name] and the checkout people are exceptional. Dr. [name] is absolutely wonderful and on top of new things and new medications. One of the most important things about her is that she definitely takes time to listen to my concerns and then addresses them. She is a “keeper!”

“Needed more time.”

“Dr. [name] always takes the time to make me feel like more than another body she is trying to get in and out as quickly as possible. I feel like she cares about her patients and shows that by sitting down and taking time to thoroughly discuss patient concerns and questions.”

“Because Dr. [name] was a little late in coming in (which was not really explained since this was an 8am apt), I felt that the time spent was somewhat rushed even though we went through my entire medical history, recent blood test results, current medications, etc. Although this was to be an annual physical exam, except for giving a urine specimen, there was nothing else done that isn't already done at a Diabetes follow up appointment. I had to check back with Dr. [name] through email to make sure that my Rx had been sent to Pharmacy as this was not in the printed report.”

“Dr. [name] took time with me and listened to my health concerns.”

“I felt [physician name] did not spend enough time with me in and out 15 minutes or less. Honestly was in and out so fast felt like I was rushed, didn't check my ears up my nose. Went for sinus/wasted visited.”

Both appointment slot lengths and patient panel sizes were found to be important to patients. Our study found that patients typically recognize that many primary care providers have standard appointment slot lengths and large patient panels. As such, providers are at times, unable to always accommodate more time with their patients.

Key Primary Care Theme III

Patients also cited the importance of care coordination of medical history to drive continuity of care. Our findings suggest that primary care patients *appreciate the continuity of their care and having a provider who knows them clinically and personally is important*. Clinical history and personal familiarity during provider handoffs were found to be important to patients whether it relates to switching to a new PCP or seeing another PCP when their regular PCP is not available:

“I was very impressed with the provider, after making the apt. they called me back to make a longer apt. as the provider did not know me so wanted a longer visit with me. She knew what my problem was very shortly after seeing me. Her diagnosis made perfect sense and I agreed with how she wanted to handle it. With a follow up apt. if I felt I need it, after my regular Dr. comes back to work. I feel very well taken care of. This practice takes excellent care of me.”

“I wouldn't consider going anywhere else. Dr. [name] is my usual doctor and she is wonderful. Dr. [name] was her replacement the day I was there and I really thought she was great. I love that office and the staff. I feel like family there.”

The coordination of referrals and prescription refills were also found to be of importance to primary care patients as related to coordinating their care:

“When we needed a rewrite of a prescription, the pharmacy called to request a new prescription. The physician who was called was unavailable and the staff failed to refer the request to my primary care physician. We had to ask the pharmacy to redo the request.”

“My original doctor left the practice. This one was assigned to me as a new PCP. I came to see her for a refill of a medication with virtually no side effects and that has had a stable dose for 12 years. She ordered several labs that didn't make any sense. I'm a physician myself and would not have ordered them, and she could not explain to me why she needed this information. No other doctor has ever ordered these labs before, and I would not have ordered them myself. She insisted that she could not refill the medication without these labs. I felt blackmailed into getting these unnecessary labs in order to get my refill -- unsurprisingly, the results were all completely normal. I will not see this provider again.”

In line with the ACO model, many would argue that PCPs are acting as quarterbacks in the care of patients. Consistently coordinating care with the appropriate stakeholders (i.e. specialty providers, pharmacies, etc.) at the right time is important to primary care patients.

The most prominent themes across the specialty care practices are presented in the following section.

Key Specialty Care Theme I

The results of this study suggest that specialty care patients in the outpatient space inextricably value and appreciate *provider and care team clinical knowledge and quality outcomes* over other elements of their care experience. Our findings may best relate to our third research question surrounding whether or not there exists differing levels of patient appreciation for a primary care provider versus a specialty care provider:

“Dr. [name] is an excellent human being and an excellent surgeon. Performed my surgery with the best possible results. Nice & clean and fast recovery. I shall recommend him for all my family members & friends.”

“Dr. [name] and his team is simply outstanding. While in the E.R., it is never good news to hear that you need surgery as soon as possible, but once we found out that Dr. [name] was performing it, our entire family relaxed as he had performed a complex surgery on a family member in March 2016. His ability to instill confidence in both the patient and family members is greatly appreciated. Not only was Dr. [name] outstanding in the care he provided, while he was away, his team mate Dr. [name] complimented the care by spending the appropriate amount of time with my family (non-native English speakers)

and when there were complications, he explained it in such a way that was non-alarmist, but was also very to the point. The team approach was greatly appreciated!!! When [hospital name] discharge instructions were in direct conflict with Dr. [name] instructions, Dr. [name] (my primary care) took immediate action to clarify that I was to follow the Surgeon's instructions.... Dr. [surgeon name] quickly verified this as well. One last comment, Dr. [surgeon name] went over lab/pathology reports with me in detail from my surgery... incredible. He explained the reports in detail and terms that I, as a laymen, could understand. Very greatly appreciate Dr. [surgeon name], Dr. [surgeon 2 name], and Dr. [pcp name] teaming on this effort.”

“Dr. [name] saved my life by removing the upper lobe of my left lung due to cancer. From the first time I met with him two years ago, he made me feel that everything was going to be ok. I trusted him completely with my care. He is the most compassionate doctor I have ever worked with. He always took the time to explain to me what was going on and what to expect. He always takes his time with appointments and genuinely cares about what he does and how the patient feels. He makes sure you completely understand what is going to take place in your treatment and patiently answers any questions you might have. If only all doctors were like him!”

“I am still around because of Dr. [name] who performed 2 complex cardio-vascular repairs. He is the best both as a cardio-vascular surgeon and as a human being. As one of the physician who intervened in the operation after I had complications, I am a miracle made possible by Dr. [name].”

Despite several other elements that have the potential to influence the patient experience, having confidence in the provider and care team matter the most to specialty care patients.

Key Specialty Care Theme II

Clear and timely communication of available care or treatment options in a way that the patient [and their family] understands is important to specialty care patients. Although we found that all patient types appreciate being kept informed and having clear care instructions, we found this theme to be more prominent with specialty care patients. Timely updates relating to any part of a patient’s care plan matters to specialty patients regardless of the setting (e.g. outpatient clinic, in hospital, at home, on telephone). One may argue that this second specialty theme is linked to

specialty theme I in that chief concern for the best possible clinical outcomes may drive consumer desire to constantly be kept informed and have clear care instructions:

“Going into surgery and feeling much more confident due to Dr. [name] and staff. A very positive experience...the explanation and care provided have helped diminish my concerns about orthopedic surgery...job well done by this doctor/team.”

“For a man recovering from abdominal surgery, a little more information about the possible difficulty or delay in resuming urination due to a swollen or enlarged prostate gland would have been helpful.”

“I had a surgery which went well but unfortunately I had an allergic reaction to not only the anesthesia but also the nausea patch placed behind my ear. Upon completion of the surgery, I got little information about what happened and what to expect following this adverse reaction. It’s been a difficult several days since--certainly not what I expected, and I wanted more care/communication about what happened and what to expect in the days/weeks to come. With that aside, I’ve been very pleased with dr. [name] and the entire staff.”

When patients are constantly being kept informed with clear care instructions and updates, they may experience a greater level of relaxation and comfort resulting in decreased levels of stress and pain. We present our final prominent specialty theme in the next section.

Key Specialty Care Theme III

In addition to having confidence in provider and care team clinical care aptitude and being kept informed, *we found that specialty patients also highly value and appreciate a stress and pain-free care experience.* This does not imply or provide any presumptions surrounding primary care patient appreciation for a stress and pain-free experience. Our study found specialty patients to value being kept at ease more so than primary care patients. These findings also help address our second research question surrounding what matters most to specialty care and primary care patients during their care experience:

“I’ve spent a lot of time working in other hospitals and am always leery about going to them. I have to say that the care I was given at Doctor [name] office, by both him and his staff, as well as the care for my inpatient procedure at Hospital [name] exceeded my expectations by a long shot. Thank you for making everything stress and pain free.” –

“Dr. [name] and her staff were wonderful, helpful, honest, caring. I was a wreck emotionally thinking I may have cancer. The doc and nurse tilted my entire state of mind and I left feeling and knowing whatever “it” was, I could handle it. They were my angels that day & I will never FORGET them.”

“Dr. [name] put my mind at rest by explaining what was going on, showing me the CT scan and what the next step is before surgery. I feel very confident with her handling my case.”

“Dr. [name] is an excellent surgeon with strong listening skills, bedside manner and he has a calming effect on very nervous patients. I interviewed another well-respected surgeon at [organization] in [city name] and decided to use Dr. [name]. Best decision I ever made!”

These study findings have helped to address the first three research questions while the additional themes presented in Table 9 may help address our fourth and final research question, do specialty care providers communicate differently than primary care providers?

In addition to the key themes, both primary care and specialty care patients appreciate a patient-centered provider and care team. Communicating in a professional, caring and compassionate manner is valued across both patient populations, however this study did not find that patients perceive that specialty providers communicate differently than primary care providers. All patient types simply appreciate care and communication that is professional, personable, caring, mindful/present, kind, friendly and polite:

“Having Dr. [name] as my primary care physician is phenomenal. I feel the same warmth and caring I had with my retired doctor of 30 years. She listens to me intently when I discuss my health concerns and responds in her usual caring way. Her knowledge of my problems gives me much peace of mind.”

“With lingering flu symptoms and fatigue, all the staff was caring and concerned. It was a relief to be evaluated and I felt the care was exceptional. I had never [previously] seen

Dr. [name]. She was professional, kind and caring. Her follow up in My Chart was timely.”

“Dr. [name] is an outstanding physician, very caring, always friendly and approachable, always professional. Since I retired 4 years ago, I have become more needy, due to so many medical concerns simultaneously. Dr. [name] has been right there for me, every step of the way, for which, I am forever grateful.”

“My visit which was an initial meeting, was one of the best experiences I have had with the medical community service I was a child. I could not be more grateful or feel more acknowledged, known or seen.”

“Dr. [name] is terrific. You should have her teach other Doctor's on how to interact with people. Dr. [name 2] was fantastic as well.”

“Dr. [name] is a caring, competent doctor. Would recommend her to anyone. Couldn't find anyone more capable and patient friendly. Office staff couldn't have been more friendly & nice.”

Our findings found that access and accurate coordination of care (accurate referrals, prescription refills, etc.) to be important to both patient types. Primary care patients value access to their providers and short wait-times as well as proper referrals to appropriate specialists. Specialty patient’s value access, ease of coordination of their procedures, if applicable, and accurate referrals from their PCP to a specialist.

One area of distinct difference between the two patient types in this study was the use of MyChart, a personalized and secure online communication portal providing patients access to their care team and pieces of their medical record. “Patients have personal and family health information at their fingertips with MyChart. They can message their doctors, attend e-visits, complete questionnaires, schedule appointments, and be more involved in managing their health” (Epic Systems Corporation, 2016, para 1). Patient comments related to the convenient and easy use of MyChart was found to be more frequent and prominent in the primary care environment. Our study found alternative communication methods such as in-person and telephonic correspondence to be the most frequent avenues for specialty patients.

Additionally, the use of kiosks and centralized scheduling at select practices in this study had an overwhelming negative response from primary care patients. Patients noted the use of kiosks to be impersonal, duplicative and not private, while centralized scheduling intake causes more issues with coordinating care, than it resolves.

Discussion

In the context of our initial problem statement, that key patient impressions responsible for driving the numerical CG CAHPS data (quantitative percentiles) between primary and specialty care service lines in both high and low performing sites are unknown, has been partially addressed through this study.

The aforementioned key thematic categories across both the primary care and specialty care ambulatory environments have provided valuable information for healthcare professionals to better understand what matters most for different patient types in the outpatient setting.

This is the first study that we know of explicitly examining, comparing and contrasting primary care to specialty care experiences. Our findings are based on actual commentary obtained from patients and suggest that healthcare delivery organizations that are able to better understand the key patient experience enhancers between primary care and specialty care patients will be better equipped in their pursuit of treating the whole patient.

Practices were intentionally selected based on provider quality scores or CG CAHPS percentile scores on likelihood to definitely recommend (top-box). Key patient statements were examined using a purposefully stratified sampling approach and illustrated a clear association between provider/practice quality performance (percentile score) and patient comment rating (negative, positive, mixed, neutral).

The results do suggest that specialty care patients are more concerned with getting well and having the best possible clinical outcomes upon completion of their specialty care treatment plan. This may suggest greater appreciation of provider and care team technical aptitude in the specialty care sector over primary care. This difference may lend itself to an association between patient perceived severity of diagnoses and perceived technical expertise of providers and warrants further exploration.

We suspect that the heightened use of MyChart amongst primary care patients in this study may be due to the nature of the inquiries in primary care as opposed to specialty care. Patients typically get referred to specialists for more complex and acute care issues.

At this time, our findings surrounding the use of kiosks and centralized scheduling in the healthcare environment are for information purposes only and will require further exploration and validation, if improvement efforts are to be considered.

As previously noted, doctor communication has been evidenced to be the strongest predictor of overall provider ratings for both primary care (Hargraves, Hays & Cleary, 2003; Tallman et al., 2007; Wilkins, Elliott, Richardson, Lozano & Mangione-Smith, 2011) and specialty care (Ruiz-Moral, Perez Rodriguez, Perula de Torres & de la Torre, 2006; Sofaer, Crofton, Goldstein, Hoy & Crabb, 2005). Our findings did support this evidence across both care environments, but in different ways. Furthermore, our findings support those of Bartlett et al. (1984) and Roter (1977) in that *providing clear explanations* and *taking the time to listen to patients and their families* are two of the chief provider communication elements most important to patients.

Primary care patients were found to greatly appreciate provider listening and time spent with the provider. The ability to practice presence, make eye contact and intently listen is a

critical part of provider communication. Additionally, the coordination and continuity of care in the primary care environment has concrete roots in provider communication. Obtaining proper clinical patient history and personal familiarity with patients requires caring communication in a way that the patient understands. Coordination of provider coverage, appointment referrals and prescription refills also require clear and consistent communication. Although the study results indicate that specialty patients are most concerned with provider and care team clinical acumen, being kept informed with proper care instructions and timely updates rank highly as well and require constant communication with patients. Furthermore, specialty patients' appreciation of a stress and pain free experience can be argued to be driven by clear communication of care instructions and being kept informed.

Our study findings challenge existing literature indicating that the majority of specialists do not leverage a patient- and family- centered approach, but a managerial style (Ruiz-Moral, Perez Rodriguez, Perula de Torres and de la Torre, 2006). Our analysis of specialty patient comments did indicate that specialty providers exhibit high levels of empathy during patient interactions and have been effective in providing a stress and pain-free experience for specialty patients. This parallels the findings of Chaitoff et al. (2017), who found particular specialty providers to exhibit higher empathy scores when using internal medicine as the point of reference.

Numerous study limitations deserve mention. Given the focused research questions in this study, the simplicity and straightforwardness of the general inductive approach provides for a convenient and operative way for analyzing the data in this qualitative study (Thomas, 2006). However, the *general inductive approach lacks strength* in comparison to some of the other approaches in the theory or model development space in qualitative research (i.e. grounded

theory, discourse analysis and phenomenology) (Thomas, 2006). This study was exploratory and we found our method of analysis to be an appropriate match for the research question(s).

Secondly, the *peer provider quality checks* by our study evaluators were intended to assess the trustworthiness of our research and is based on both the study team shared experiences and individual experiences (Lincoln & Guba, 1985). Individual experiences and perceptions are subjective and could have held personal biases. This may be driven by personal perceptions and specific evaluation outcomes interests.

Third, *practice size* was not thoroughly considered. Although moderately comparable in this study, we did not deliberately stratify by practice size or provider FTEs. Practices ranged from 1.88 FTE providers to 7.75 FTE providers. Provider FTE count may influence several aspects such as staffing levels, budgets, local cultures, team engagement levels, operational workflows and individual patient experiences. Kane (2017) indicates that the majority of providers (57.8%) remain in small practice settings of ten or fewer and that between 2012 and 2016, there has been a steady shift toward larger practice sizes. The percentage of providers working in practices of 50 or more was 13.8% in 2016, up from 12.2% in 2012 (Kane, 2017). Furthermore, multispecialty practices have historically been larger than single specialty practices. Among providers in single specialty groups, 38.9% were in practices with fewer than five providers and only 5.0% were in practices with 50 or more. Our selected single specialty practice sizes support the findings of Kane (2017) in that all but one had five or fewer specialty providers. This allows our findings to be more generalizable to comparably sized specialty practices. Ambulatory practice size industry benchmarks provide a range for which a future study may use to identify and select proportionally sized practices to be assessed on quality performance.

Fourth, we do recognize the limitation of specialties in this study and that additional specialty service line comparisons should be considered for future research. *Comparison between specialty care divisions and multispecialty practices was not considered.* Our specialty sample was limited to the division of surgery and neurology based on top, median and low quality performing practices. Patient care experiences and perceptions may differ between specialty care divisions (e.g. surgery and cardiology) and multispecialty practices. Quigley et al. (2013) concluded that specialists should focus on particular aspects of communication that are most important for patients receiving care in that respective specialty. Spending enough time with the patient was the most important communication element for interventional radiology, however infectious disease patients did not find this communication dimension important. Easy-to-understand instructions mattered the most to geriatric patients and pulmonary patients, while provider showing respect was particularly significant for plastic surgery patients. Providers showing respect was determined to be a chief focus across all specialties (Quigley et al., 2013).

Fifth, *patient comment ratings (negative, positive, mixed, neutral)* were generated through a sentiment analysis based on particular words or phrases in the patient comments themselves. Ratings were not individually audited by actual human researchers in this study.

Sixth, *market factors and patient demographics* were not directly considered in this study. The VBP movement has been intended to align reimbursement levels with care quality outcomes, however there exist several environmental market factors that influence quality outcomes that are out of the control of both healthcare leaders and health policy makers ((Kazley, Ford, Diana & Menachemi, 2015). Although outside of the scope of this study, Kazley, Ford, Diana and Menachemi (2015) concluded there to be significant differences in patient satisfaction levels based on resources such as market competition, metro status, patient

expectations and provider access. These results should be considered “with the understanding that patient satisfaction is likely the result of a strategy to improve patients’ perceptions of their care” (p. 41). Their study found a negative correlation between the patient population aged over 65 years of age and the likelihood to definitely recommend the hospital. It was also found that as the availability of general practitioners increases, the likelihood to definitely recommend the hospital decreases. Alternatively, the study found a positive correlation between an increase in unemployment levels and the likelihood to definitely recommend the hospital and availability of specialty practitioners and the likelihood to definitely recommend the hospital.

Our study may have been limited in that it did not incorporate environmental market factors that may have had the potential to influence patient perceptions and CG CAHPS survey patient comments and may be ripe for future evaluation.

Lastly, *the organizational control variable in our study was an academic community medical group model*. Given the presumption that academic medical centers (AMCs), community healthcare organizations, and private practice models may have differing missions and research agendas, the medical group associated with this study was part of an urban AMC and the generalizability of the findings may be limited. In support of our findings, independently owned provider practices have shown to be decreasing from 48.5% in 2012 to 32.7% in 2016, while providers identifying as hospital-based or medical group staff have increased from 43.7% in 2012 to 57.9% in 2016 (The Physicians Foundation, 2016). This clearly illustrates the movement of provider staffing models away from traditional private, independent practice and toward an employed model (The Physicians Foundation, 2016). Furthermore, Kazley, Ford, Diana and Menachemi (2015) found a negative association between teaching status and the

likelihood to definitely recommend a hospital. Our study did not explore associations or correlations, if any, between teaching status and likelihood to definitely recommend.

Conclusion

Healthcare organizations wishing to [1] effectively manage the whole patient and [2] to potentially maximize reimbursements under the VBP model may be ill-equipped in the absence of a clear understanding of the key elements responsible for driving patient experience related quality scores (CG CAHPS quantitative percentiles) between primary and specialty care services. The need for a better understanding of how and why patients form particular impressions across service lines in the ambulatory environment was partially fulfilled through this study.

In addition, while not part of our primary research agenda, we did note that numerous patients used the free text comment box to qualify the quantitative score. This supports the mixed methods design in that qualitative data may be used to assess the validity of quantitative results (Fetters, Curry & Creswell, 2013). For example, comments stated *“the depression affects my following directions, this affects my ratings”* and *“a little more than a year ago I was given an optometrist in [city] who misdiagnosed a simple infection a number of times.”* As these survey comments illustrate, relying solely on the quantitative data (likelihood to recommend) may not paint the entire picture. Without a multi-method examination of both the quantitative and qualitative CG CAHPS data, practices may be missing key contextual information.

Recognizing what matters most to particular patient types and taking actionable systematic steps toward molding each individual patient experience is both attainable and may be generalized across care delivery settings. Additional research is needed to support the transferability of our findings. Obtaining a clear understanding that every healthcare related

interaction is a high-stakes interaction may be best achieved if first, we understand what matters most for particular healthcare consumers during their experiences.

This study has provided evidence in support of step eight in Berwick's (2016) proposed change era of medicine, hearing the voices of the people served. Some of us argue, that this may just be the tip of the iceberg in better understanding the patient perspective and learning how to "ask less, what is the matter with you? And more, what matters to you?" (Berwick, 2016, p. 1330).

Protection of Human Subjects

All data was masked and no patient identifiers were included in the analysis of this study. The internal review board (IRB) responsible for the medical group accepted the study proposal for expedited review.

Declaration of Conflicting Interests

Study author(s) declared no potential conflicts of interest with respect to the research itself, authorship, and/or the publication of this paper.

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