A Mixed-Methods Exploration of Hidden Access in Primary Care

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

Background
- Main attributes of primary care include quality of care, efficiency of care, and equity in health.
- 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:

<table>
<thead>
<tr>
<th>Practice and Controlled Status Comparisons</th>
<th>Percent difference compared to baseline (Practice B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice A, controlled Diabetes</td>
<td>30.2%</td>
</tr>
<tr>
<td>Practice C, controlled Diabetes</td>
<td>19.3%</td>
</tr>
<tr>
<td>Practice C, uncontrolled Diabetes</td>
<td>40.1%</td>
</tr>
<tr>
<td>Practice C, controlled Hypertension</td>
<td>27.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice and Controlled Status Comparisons</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( p^* )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice A, controlled Diabetes</td>
<td>0.26384</td>
<td>5.568</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Practice C, controlled Diabetes</td>
<td>0.17618</td>
<td>4.852</td>
<td>&lt;.001*</td>
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<tr>
<td>Practice C, uncontrolled Diabetes</td>
<td>0.16777</td>
<td>2.069</td>
<td>0.04*</td>
</tr>
<tr>
<td>Practice C, controlled Hypertension</td>
<td>0.23911</td>
<td>10.990</td>
<td>&lt;.001*</td>
</tr>
</tbody>
</table>

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: