WALDEN UNIVERSITY
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2015

Health Care Reform and the Transition from Volume to Quality Payment Models: A Primary Care Focus

Kevin Lee Jackson
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations


Part of the Medicine and Health Sciences Commons, and the Public Policy Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Kevin Jackson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Suzanne Richins, Committee Chairperson, Health Services Faculty
Dr. Ronald Bucci, Committee Member, Health Services Faculty
Dr. Vibha Kumar, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

Health Care Reform and the Transition from Volume to Quality Payment Models: A Primary Care Focus

by

Kevin L. Jackson

MHA, Seton Hall University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

April 2015

Abstract

The 2010 Patient Protection and Affordable Care Act (PPACA) resulted in providers and health care organizations conforming to new payment models that connect reimbursement to patient outcomes. Primary care providers (PCPs) are tasked to provide new quality provisions as chronic disease management is a key focus to improve outcomes. The purpose of this study was to understand the transition to new payment models and determine whether care is improved. The conceptual framework is grounded in health care access models geared towards the improvement of quality outcomes including the chronic care model (CCM). The research questions were designed to understand providers' perspectives on new metrics to improve quality and the implications on practice workflows and patient outcomes. This phenomenological study consisted of interviews with 9 PCPs directly impacted by health care reform and the implementation of new quality metrics designed to improve patient outcomes. The study analyzed PCPs' perspectives on health care reform and the transition to new quality focused payment models and determined if quality is improved. Collection of data was designed to understand PCPs' challenges in alignment of their medical practices to newly defined provisions of quality expectations. Respondents reported concern with new payment models focused on quality outcomes and reported overall patient care had not improved as a result of alignment of quality initiatives to payment. The implications of positive social change will be an improved understanding of new models of payment intended to maximize reimbursement and address potential challenges with the implementation of quality metrics in order to effectively improve patient outcomes.

Health Care Reform and the Transition from Volume to Quality Payment Models: A Primary Care Focus

by

Kevin L. Jackson

MHA, Seton Hall University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

April 2015

Dedication

I dedicate this dissertation to my children, Dallas and Charli Jackson who stuck in there with daddy through all the long hours and days of researching and writing. This dissertation is also dedicated in loving memory of my late brother, Fontaine Jackson. We all miss and love you very much.

Acknowledgments

I thank God for providing the strength and motivation to endure the journey of completing my dissertation. Without God, this opportunity would not have been possible.

Special thanks to my wife, Courtney Jackson for the many days of patience and sacrifice while I worked towards completion of my Ph.D. I could not have accomplished this long and challenging endeavor without the continuous support you provided. I am truly grateful to have you in my life.

Johnnie Gay, I thank you for the many years of mentoring and spiritual guidance. I am very appreciative of the countless words of encouragement which have contributed to my professional success over the years.

Drs. Suzanne Richins and Ronald Bucci who accepted the invitation to serve as my chair and committee member, I thank you immensely for your guidance through the dissertation process. I appreciate your knowledge and expertise in helping me achieve my highest academic accomplishment.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

In 2010 the Patient Protection and Affordable Care (PPACA) was signed into law and has resulted in increased pressure on health care organizations and providers to conform to new provisions of payment models that focus on quality outcomes. The legislation was specifically designed to improve quality and simultaneously cut the cost of care (Duska & Engelhard, 2013). Primary care providers (PCPs) are in a unique position to provide leadership in the transition of health care reform as PPACA provisions require coordinated, comprehensive patient care with specific emphasis on disease prevention and health promotion (Calman, Hauser, Leanza, & Schiller, 2012). It is important that organizations strategically prepare for new payment models focused on quality if reimbursement is to be maximized. With such focus in the PPACA on quality outcomes, it is presumed that commercial payers will continue to increase payment model expectations.

The implementation of payment models with greater emphasis on quality may improve patient outcomes. Primary care providers will need to ramp up their focus on population health and improve overall communication and coordination of care in order to meet standards of care which connect reimbursements to measurable quality outcomes. Chapter 1 includes a summary of evidence of the problem which supports the need to understand the implications of the implementation of payment models with focus on quality. There is an overview of the purpose, significance, and conceptual framework that grounds the study. The chapter also contains rationale for the selection of a qualitative methodology, assumptions, and delimitations of the study.

Background of the Study

The cost of health care has continued to rise over the years with reimbursements tied to volume of services provided as opposed to the quality of care. Nearly 50 million uninsured Americans lack adequate access to health care that results in a quality gap due to uneven care (Coalition for Affordable Health Coverage, 2010). The PPACA has advanced a reevaluation in payment models that now focuses on outcomes and quality measurements (Abrams, Nuzum, Mika, & Lawlor, 2011). The intent of the study was to provide insight to provisions of the PPACA which focus on payment models aimed to improve quality and whether the law denotes quality through perspectives of providers. The study also addresses the effectiveness of the quality provisions of the PPACA and if the initiative measurably improves the quality of care.

To improve quality of care, the PPACA highlights specific emphasis on the role of PCPs to spearhead improved outcomes. In order to enhance access, improve quality, and contain costs, the United States must fundamentally strengthen its primary care workforce (Patient Protection and Affordable Care Act, 2010). Due to the severe shortage of providers, increased patient demand, and diminishing supply, millions of newly insured individuals will be denied access despite coverage (Schwartz, 2012). Primary care is essential to health care reform and in order for organizations and providers to maximize payment under new provisions of the PPACA, care delivery must be aligned with specified quality expectations. Primary care providers face increased

pressure to conform to quality payment models as many initiatives are around the care they deliver.

The transition to quality payment models comes with many challenges for health care organizations and providers involved. Physicians, hospitals, payers, and policy makers have a significant challenge ahead to manage the transition to new payment models primarily due to the confusion to select from numerous models (Silverman, 2011). To decrease health care cost, the system must transition away from traditional fee for service (FFS) payments that reward providers for volume regardless of need, effectiveness, or quality (Shomker, 2010). The intent of this study was to analyze the transitions to these new payment models and determine through the perspective of providers if quality is measurably improved. The effectiveness of many quality initiatives remains to be determined as outcomes continue to be researched.

The study will address the gap in literature around what the PPACA denotes as quality of care compared to perspectives of providers and determine if new payment models improve quality of care. New payment models with focus on quality are one of the most important strategies of the PPACA (Silverman, 2011). The PPACA has put significant pressure on health care organizations to conform to new provisions of quality payment models and prepare providers and staff for new care delivery models that foster improved patient outcomes. The intent of this study is to research initiatives which connect payment to quality and contribute knowledge on how providers' quality definitions align with those of the PPACA. The providers' perspectives are based on

actual patient encounters and the work that is involved to care for patients. It is important to understand provider feedback as many quality initiatives require medical care to be transformed in order to align with the identified provisions of the PPACA.

This study is needed to evaluate new payment models outlined in the PPACA with specific focus on quality outcomes and determine if the quality initiatives are parallel to definitions of quality from health care administrators and providers. The study was also needed to analyze the specifics of new quality initiatives and evaluate if care is improved measurably. The development and implementation of new payment models illustrates one of the most important provisions of health care reform and is considered the leading strategy of reform (Silverman, 2011). The PPACA has a fundamental impact on the health care system to add value to the money spent on health care (Davis, 2010). To maximize reimbursements, efforts of providers and organizations must be aligned with new provisions of the PPACA. This study will report on the transition to new quality focused payment models in organizations and the challenges that take place.

Problem Statement

The health care delivery system in the United States will need to make multiple changes over the next few years to meet goals for provision of optimal quality and safety parameters for patients (Ricketts, 2011). The PPACA of 2010 increases the number of individuals who will be eligible for Medicaid and creates subsidies for uninsured lower-income Americans without access to employer-based insurance to purchase insurance in exchanges (Hofer, Abraham, & Moscovice, 2011). Researchers have projected that 32

million individuals will gain access to medical care under provisions of the PPACA (Goodson, 2010). This sharp growth will put increased pressure on physicians to perform at higher levels of quality in less time and while adjusting to electronic medical records (EMR).

Provisions of the PPACA have highlighted the role of PCPs as the gateway to manage chronic disease and improve care coordination. Primary care practices must plan for newly created payment models that focus reimbursement on defined quality metrics outlined in the PPACA. In the near future, providers will need to be prepared for employers not only being concerned about the details of their clinical performance but also their contracts as quality metrics will play a role in how they are compensated (Delbanco, 2011). Health care organizations and providers will need to plan for the anticipated transition to connect payment to performance as health care reform is rolled out (Delbanco, 2011). Many provisions of the PPACA connect payment to quality outcomes and whether care is improved measurably needs to be determined.

Purpose Statement

The purpose of this qualitative, phenomenological inquiry is to understand the transition to new payment models which connect reimbursement for medical care to quality outcomes under provisions of the PPACA. Primary care providers play an instrumental role to improve the quality of care delivered and the specifics of their responsibilities under new provisions of the PPACA will be defined. The research will take place in corporate primary care practices. For this study, new payment models that

connect to quality outcomes will be generally described as initiatives outlined in the PPACA which are directly linked to the value of care provided and the level of qualified reimbursement.

The study will highlight the anticipated changes in payment models that will connect reimbursements to quality outcomes and seek providers' input. This is important because providers will need to consider the variables associated with payment reform to include the following: (a) implications to patient visits, (b) personal compensation, (c) how quality will be measured, (d) adjusting to EMR quality metrics, (e) defining patient flow and who does what in the office, and (f) how physician to patient relationships will be impacted by seeing more patients in less time while adding additional quality metric responsibilities.

Research Questions

The following research questions will guide this study:

RQ1: What quality metrics are primary care practices of health care organizations implementing to improve patient visits?

RQ2: What are the concerns from physicians with having to meet the quality provisions of the PPACA?

RQ3: Are physicians concerned that focusing payment on quality will decrease compensation due to potentially limiting the number of patient appointments?

RQ4: How will quality metrics impact providers' ability to see more patients in less time?

RQ5: Are physicians in agreement that reimbursements should be based on meeting quality metrics?

RQ6: Should quality measures play a role in employed physician contracts?

RQ7: Are physicians experiencing improvements in the quality of care being delivered as a result of quality initiatives?

Conceptual Framework

The conceptual framework for this qualitative study is grounded in the knowledge of health care access models that addresses the parameters of the PPACA and the chronic care model (CCM) which is geared towards the improvement of quality outcomes. Models on access and chronic care management are key initiatives for health care reform. The PPACA has changed the way at which health care is delivered and monitored with specific emphasis on access and quality. It is estimated that nearly 50 million uninsured Americans lack adequate access to health care (Coalition for Affordable Health Coverage, 2010). Payment models have specifically been redefined in the PPACA and now focus on outcomes and quality measurements (Abrams, Nuzum, Mika, & Lawlor, 2011). The primary objectives are to improve access to care for millions of individuals and optimized the quality of care delivery. Access models of health care are key to understand the gateway to medical care.

Models on access to care indicate the PPACA that the gateway to medical services is through primary care visits. The three models on access which ground this study are (a) Penchansky's model, (b) The Institute of Medicine (IOM) model of access monitoring and, (c) the behavioral model of health services use (Karikari-Martin, 2010). In the history of health policy, the definitions of access have evolved from the ability to get insurance coverage, to the number of providers, to efficiency of health care services (Gold, 1998). The PPACA intends to improve quality of care by the increased utilization of primary care access to close gaps in care. Each of the models of access is useful to inform the PPACA on access experiences and challenges. Models on access relate to the study as the PPACA has provisions to increase access to care and subsequently improve the quality of care delivered. This study evaluates the PPACA as it relates to access and the improvement of care delivery.

Penchansky's Model

Penchansky's model is a concept used to measure access. The Penchansky framework was developed in the 1980s to provide a direct tool to define and measure access which was viewed as specific components of a fit between patient needs and the health care system (Penchansky & Thomas, 1981). Penchansky measures access through (a) availability, (b) accessibility, (c) accommodation, (d) affordability, (e) and acceptability (Karikari-Martin, 2010). It is estimated by 2019, annual primary care visits will increase between 15.07 million and 24.26 million as a result of health reform's expansion in coverage initiatives (Hofer, Abraham, & Moscovice, 2011). The Penchansky model informs the PPACA on access issues as seen through the five

measures of access. The framework is important to the study as it provides a contextual lens of primary care utilization through the five measures of access.

Institute of Medicine Model of Access Monitoring

The Institute of Medicine (IOM) model of access monitoring was developed in the 1990s to specifically provide a structure of timely care to achievement of optimal outcomes (Institute of Medicine, 1993). The model provides aspects of access related to barriers to care and use of services (Karikari-Martin, 2010). The conceptual framework of appropriate care at the right time tied to quality outcomes has been a topic of discussion for several years as noted back to the 1990s by each President and Congress. One of the objectives of the PPACA was to implement health insurance reform to allow timely, affordable access to care and to enhance quality and decrease costs of health care (Hass, 2013). The IOM model relates to the study through the connection of access barriers to identified provisions of the PPACA to improve access and close gaps in care. The model will help answer qualitative research questions related to efficiency of care and strategies to optimize the quality of care delivery.

Behavioral Model of Health Services Use

The behavioral model was originally developed in the 1960s specifically to inform policy makers on the motive for why families use health services (Andersen, 1995). The model provides a framework to understand how access to care is influenced by community-level and individual-level characteristics (Davidson, Andersen, Wyn, & Brown, 2004). The basis for the model is to understand access to care based on where

people live and the available medical resources and individual decisions people make about their medical care. The PPACA has provisions to expand Medicaid to provide health insurance to millions of uninsured adults and children across the country (Duska & Engelhard, 2013). Each state has a considerable amount of autonomy to shape eligibility for Medicaid services, which has resulted in wide variations in the program from state to state (Cantor, Thompson, & Farnham, 2013). The Behavioral Model relates to the study as it informs the challenges ahead with access to care through Medicaid expansion with states' participation varying which limits access for many people. The individual-level characters also relates to the study as many people may elect not to participate in health insurance exchanges which are intended to increase access to care.

Chronic Care Model

The study is grounded in the knowledge of the CCM as many health reform initiatives are focused on quality improvements through management of chronic disease. The model was developed by Edward Wagner as a foundation to redesign practice workflows of primary care and align with the patient-centered medical home (PCMH) model (Suter, Hennessey, Florez, & Newton Suter, 2011). The CCM provides a framework for primary care practices to restructure care delivery with specific focus on chronic care management and commitment to provide comprehensive quality care to all patients (Molina-Ortiz, Vega, & Calman, 2012). The PPACA includes provisions of the PCMH to test innovative payment models designed to reduce expenditures and enhance quality of care (Mechanic & Altman, 2012). The CCM relates to the study as it provides a framework to understand how chronic disease management in primary care improves

quality and maximizes payment. The model contributes to key questions of the study which pertain to the improvement of quality outcomes by closing gaps care.

Nature of the Study

The nature of this study is qualitative with a phenomenological approach. Phenomenological research is useful in identifying human experiences about a phenomenon as described by the participants (Creswell, 2009). This research specifically inquires about the experiences of physicians and their perspectives on health care reform and the shift to focus payment models on quality outcomes. A phenomenological approach is best for this study because it allows physicians and administrators to be interviewed on specific questions about their transition to quality measures as the primary focus of payment for health care services. A phenomenological approach enables very specific accounts on the practice experiences of the participants and the implications of new quality initiatives to improve care. Health care reform requires physicians to think differently about the care provided and a qualitative design helps to understand the shift in how care is valued and ultimately paid for.

The impact of health care reform and the transition to payment models with specific focus on quality outcomes is the key concept investigated in the study. The PPACA was specifically designed to improve quality and simultaneously cut the cost of care (Duska & Engelhard, 2013). Primary care providers will be tasked with the responsibility to drive quality improvements as PPACA provisions require coordinated,

comprehensive patient care with specific emphasis on disease prevention and health promotion (Calman et al., 2012). A phenomenological approach allows for the study to inquire on the ongoing transition to quality payment models and aid in the determination if providers' experiences exemplify quality improvements as a result of health reform. Data will be collected and analyzed through interviews and surveys to make such determinations.

The data collection tool consists of face-to-face interviews and surveys with the participants. The participants for this study will be PCPs and administrators who have been directly involved in the implementation of quality initiatives which connect to reimbursement. Individuals will be selected due to their close involvement with health reform as it relates to primary care workflows to improve quality of care. Primary care providers now experience changes in practices as a result of the rapidly evolving health care environment (Peccoralo, Callahan, Stark, & DeCherrie, 2012). To collect appropriate data, the study was conducted with participants who are active in the implementation of the proposed medical practice changes to enhance quality. Data collection procedures were conducted in the physician practices for their convenience and to allow examples of workflows to be demonstrated if needed. Interview and survey questions were tested by a protocol that includes questions specific to the transition to payment models focused on quality initiatives and analyzed for participant perceptions and quality outcomes.

The NVivo software package was used to analyze and interpret the data. NVivo was chosen for several reasons to include its "security by storing the database and files

together in a single file, it enables a researcher to use multiple languages, it has a merge function for team research, and it enables the researcher to easily manipulate the categories" (Cresswell, 2007, p. 167). Data analysis was ongoing as the interviews were conducted. Patterns and themes were analyzed and recorded directly as they developed. The data were organized as collected to assist in the data analysis. Information was gathered and field notes from the interviews were used to analyze and interpret the data with the results presented in chapter 4.

Definitions

The following definitions are applied to this study:

Accountable care organizations: Groups of doctors, hospitals, and other health care providers who voluntarily come together to give coordinated high quality care to Medicare patients (Duska & Engelhard, 2013).

Bundled payments: Rather than paying each provider for separate services provided during an episode of care, the bundled payment pays one provider a single payment for all services a patient received during an entire episode to include post-acute care (Shay & Mick, 2013).

Health insurance exchanges: Exchanges designed to provide a competitive marketplace for health insurance initially for those that must purchase policies or for those employed by small business that do not offer insurance (Riegelman, 2011).

Health reform: The recently passed Patient Protection and Affordable Care Act of 2010 (Friedberg, Hussey, & Schneider, 2010).

Independent payment advisory board (IPAB): A committee comprised of members appointed by the President, pending Senate confirmation, to form policy recommendations to reduce the growth of Medicare by up to 1.5% (Filson, C., Hollingsworth, J., Skolarus, T., Clemens, J., & Hollenbeck, 2011).

Patient-centered medical home (PCMH): A model of care designed to improve care coordination to close gaps in care through enhanced access, communication between patients and providers, and adoption of health information technology (Filson et al., 2011).

Patient protection and affordable care act (PPACA): Legislation signed into law in 2010 to make health insurance reform to enhance quality and decrease the cost of health care (Haas, 2013).

Physician quality reporting initiative (PQRI): Medicare's voluntary pay-for-reporting program where clinicians choose from 74 quality measures and report on at least 3 (Halladay et al., 2009).

Primary care provider (PCP): Providers with training as general pediatricians, general internists, family physicians, or other generalist, including non-physician providers (Friedberg, Hussey, & Schneider, 2010).

Recovery audit contractors (RAC): A Medicare program launched to identify improper payments by performing post payment reviews of Medicare Part A and B claims (Robin & Gershwin, 2010).

Assumptions

In this study, it is assumed that the PPACA will improve quality of care by the connection of patient outcomes to payment models. Literature supports the quality provisions of the PPACA and expectations that PCPs will improve overall outcomes through patient communication and closing gaps in care. The assumption that quality will improve with provisions of health reform depends on several factors to include (a) patient cooperation in treatment plans designed by the provider, (b) health care organizations' preparedness for new payment models with focus on quality, (c) the controversial PPACA does not get abolished, (d) provider buy-in to new changes in the definition of quality, and (e) individuals expected to participate in health insurance exchanges to increase access to care actually sign up. The aforementioned assumptions are necessary for this study as it must be understood that to improve the value of care, there are many factors that contribute to quality improvement which cannot be generally assumed through the passing of the PPACA.

Scope and Delimitations

The scope of the study consists of PCPs and health care administrators who are directly involved in the implementation of quality initiatives outlined in the PPACA. The transition to new payment models with focus on quality is key to health care reform and

the study includes individuals with direct experiences with the process and challenges. The study is delimited to include only providers and administrators who have already undergone workflow changes intended to improve quality of care which enhances the comprehensiveness of the study. Individuals who have experienced the effects of new quality initiatives increases the potential for more direct perspectives based on firsthand practices.

Limitations

A qualitative design for this study may come with the potential weakness of limited data collection due to participant subjectivity. This study is limited by the accuracy of the interview and survey responses on specific questions on quality and payment models as they relate to the PPACA. The potential challenges are that participants may disagree with various quality initiatives that connect to payment as a result of political and philosophical differences about the PPACA. Health care reform is often regarded as controversial and has been divided between political party differences. Political differences have potential to limit data collection as people are often politically motivated and politics can drive decision making. Efforts to address limitations are focused on objective data collection techniques based on actual outcomes and limited political subjective questions.

Significance of the Study

Health care organizations continue to expand their participation in new payment programs to include accountable care organizations (ACOs) and patient centered medical

home (PCMH). Participation in these new programs is the result of provisions in the PPACA which focus reimbursement on quality outcomes. Financial incentives for performance and quality continue to grow in primary care (Scott, 2011). This study will analyze and present provisions of health care reform that focus on the shift from quantity to quality payment models and seek to understand how physicians view their effectiveness to practice medicine under these changes. The practical application of this study is to provide insight to health care organizations on providers' perspectives on payment reform that focus on quality outcomes. This will be done with anticipation that organizations will make the transition appropriately and optimize physicians' ability to practice medicine effectively.

With this study, it is anticipated that health care organizations with employed primary care physicians will be more informed and better prepared to care for the millions of newly insured individuals that will seek access to care. This study will analyze potential educational gaps in what physicians understand to be the shift from volume to quality payment models and the impact on primary care operations. The educational gaps will be identified in the results by evaluation of how familiar physicians are with payment models which focus on quality outcomes. This study is important for individuals who seek access to primary care, policy makers, and those that are directly employed in primary care practices, including providers. The implications for positive social change will be an improved physician awareness of the newly established payment models that emphasize quality measures. As physicians transition their focus from volume to quality outcomes, it is anticipated that patients will receive higher quality care

at lower cost. The cost of health care will decrease and society will see the economic financial burden from health care improve.

Summary

The PPACA was passed in 2010 and has changed health care delivery with increased attention to quality of care and payment for services rendered. Health care organizations continue to expand preparedness for new payment models focused on quality outcomes. The PPACA has specific provisions to close gaps in care with emphasis on the work of PCPs to redesign workflows aligned with improved patient communication and care coordination. It is important to redesign primary care workflows as the cost of health care expenditures continue to rise substantially with limited accountability with providers and health care organizations. The PPACA intends to increase accountability through the connection of payment models to the quality of the care provided. The transition to new payment models comes with challenges due to the numerous amount of options available and increased complexity of the payment programs. The purpose of the study is to understand health care reform and the transition to new payment models with focus on quality and obtain a perspective from providers and health care administrators if care is improve measurably. Chapter 2 provides a literature review on the various provisions of the PPACA which focus on quality improvements and payment model initiatives. The literature review includes the role of PCPs in health reform and specific initiatives implemented in primary care practices targeted to improve quality of care.

Chapter 2: Literature Review

This review of scholarly literature examines new provisions in health care reform and law that focuses on quality. Payment for medical care to practitioners and institutions is often linked to paradigms of appropriate interventions. Literature on providers' perspectives on how health reform will impact their medical practice is essential to understand the transition to quality payment models. The primary focus of this literature review is to analyze current studies that focus on health care organizations' ongoing transition to payment models aligned with quality standards and determine whether these interventions are improving patient care measurably.

The PPACA was passed in 2010 and is regarded as the legislation that will reestablish primary care medicine as the foundation for healthcare delivery in the United States (Goodson, 2010). Provisions in the PPACA are intended to prepare primary care practices for new payment models that focus specifically on quality improvement. If the primary care industry is not prepared for the shift to focus on quality of services rendered, payment will be directly impacted. The goal for payment reform is to change the way physicians are paid with an emphasis on higher quality at lower cost (Silversmith, 2011). Health care organizations continue to ramp up their participation in new payment models with ongoing challenges as a result of workflow changes with focus on quality. Providers and clinical nursing staff face challenges with increased workload requirements to meet quality expectations aligned with new payment models (Bitton et al., 2012).

The U.S. health care system is the most expensive in the world and delivers inconsistent and sometimes poor quality of care (Filson, Hollingsworth, Skolarus, Clemens, & Hollenbeck, 2011). Nearly 50 million uninsured Americans lack adequate access to health care that results in a quality gap due to a lack of follow-up routine care (Coalition for Affordable Health Coverage, 2010). The PPACA has advanced a reevaluation in payment models that now focuses on outcomes and quality measurements (Abrams et al., 2011). It is anticipated that new payment models that reward providers for quality instead of volume of care will provide care the patients want to receive (Baron, 2012). Primary care providers will need to prepare for the rapid increase in insured individuals as the PPACA implements provisions to improve quality by closing gaps in access and the connection of payment to quality. This study will analyze and present provisions of health reform that focus on the shift from volume to quality payment models and seek to understand physicians' perspective on whether or not quality is improved measurably.

The literature demonstrates health reform's strategy to implement new payment models along with a narrowed focus on payment to physicians, hospitals, and other providers that spotlight quality of care (Silversmith, 2011). Studies include (a) family medicine's role in spearheading health reform, (b) quality consequences of the patient protection and affordable care act (PPACA), (c) payment models that reflect current changes, (d) primary care quality initiatives, (e) electronic medical records and their role in primary care, and (f) quality reporting with statistical analyses. Articles included

directly address how providers and health care organizations are paid and examine emphasis on quality parameters.

Literature Search Strategy

To conduct this literature review, the health sciences library database was used. There was a simultaneous database search to include CINAHL & MEDLINE. The key search terms used to obtain the literature were (a) primary care, (b) quality initiatives, (c) patient protection and affordable care act and quality, (d) health reform, (e) payment models and affordable care act, (f) electronic health records and quality, and (g) physician quality reporting. Sufficient literature demonstrated the transition to quality payment models and the implications on primary care.

Support of Framework

The CCM serves as the basis for which the study is grounded. Founded by Edward Wagner, the CCM promotes a continuous patient care approach to include (a) identification, (b) assessment, (c) planning, (d) coordination, and (e) monitoring (Gensichen, 2006). The CCM was designed to provide guidance to the delivery of comprehensive quality care to patients. Specifically the model stimulates improved clinical reasoning for diagnosis, comprehensive assessment of patient needs, and promotion of clear therapy targets (Gensichen, 2006). Quality of care is enhanced as the CCM promotes the management of disease specific registries to monitor high-risk patients and delivery of quality reports for provider analysis (Molina-Ortiz et al., 2012).

The knowledge of the CCM provides foundational support for this study. The CCM delivers a pathway for clinical transformation of primary care which endorses a framework for health systems to align workflows and care delivery to commitment of comprehensive quality patient outcomes (Molina-Ortiz et al., 2012). The CCM concept is important to this study as the literature outlines new quality focused payment models that hold PCPs accountable for care provided and quality outcomes. In order to maximize reimbursement, PCPs must align clinical practices to newly defined quality metrics targeted to improve patient outcomes and maximize reimbursement. The foundation of the CCM provides a framework at which PCPs utilize in order to comply with new standards of alignment of quality outcomes to payment. The alignment of quality outcomes to payment under newly developed provisions of the PPACA is anticipated to improve overall health of patients coupled with a decrease in cost for medical treatment. As PCPs increase focus on management of chronic diseases, literature suggest patient outcomes subsequently improves which aligns directly with the concept of the CCM. This framework was useful in the selection of PCPs to understand the perspectives of providers on health care reform and the transition to new quality focused payment models.

Family Medicine's Role in Spearheading Health Reform

Family medicine providers play an important role in the improvement of quality of care as family physicians and general practitioners as the primary level of care are considered the gatekeepers to specialty options. Primary care providers now experience changes in practices as a result of the rapidly evolving health care environment

(Peccoralo et al., 2012). Family medicine is in a unique position to provide leadership in the transition of health reform as PPACA provisions require coordinated, comprehensive patient care with specific emphasis on disease prevention and health promotion (Calman et al., 2012). As the health care environment changes it is important that primary care physicians understand their role in health reform not only in point of service care, but also in management of quality and direct options for problem resolution (Verdon, 2012). Primary care will have the responsibility to ensure quality of care through improved care coordination and chronic disease management as patients seek preventive options from the PCP. The PPACA specifically holds primary care providers responsible to provide increased access to medical needs for the millions of newly insured individuals who will comprise the substantial increase of primary patients (Collins, 2012).

The demand for primary care providers is expected to rise as patient visits increase. It is estimated that by 2019, annual primary care visits will increase between 15.07 million and 24.26 million as a result of health reform's expansion in coverage initiatives (Hofer, Abraham, & Moscovice, 2011). Friedberg, Hussey, and Schneider (2010) argued that despite many contentious debates over health care reform, primary care providers will be essential to improve health outcomes and restrain the growth of health care spending. Provisions of the PPACA to expand coverage for primary care will need to elucidate the measures required by primary care physicians in order for quality to be maintained. As patient visits increase, these new thought and practice patterns must become automatic, perhaps different from those paradigms learned in medical school and residencies (Hertz, 2012).

If the family and internal medicine as specialties are to meet the quality standards of the PPACA, workforce demands must align with patient needs. The Patient Protection and Affordable Care Act (2010) reported that in order to enhance access, improve quality, and contain costs, the United States must fundamentally strengthen its primary care workforce. In a study (Schwartz, 2012) that examines health reform's implications on the primary care workforce, Schwartz argues due to the severe shortage of (a) primary care providers, (b) increased patient demand, and (c) diminishing supply, millions of newly insured individuals will experience unfilled promises to access despite coverage. In this study I further outline the importance of primary care providers in the transition to quality payment models. Many provisions depend on the role of family medicine and if the primary care workforce is not prepared, pitfalls will occur with limited access, payment reductions, and lack of improved quality. Despite multiple efforts to reform the U.S health care system over the years and the successful passing of the PPACA, many argue health reform as it stands today does not close the quality gap in care as physician practice workflows become more challenging.

Quality Consequences of the Patient Protection and Affordable Care Act

In 2010, the PPACA was signed into law. This law represented the combined efforts of legislators to about 2200 pages (Johnson, 2011) and represented concepts that had not been studied or researched thoroughly (Shaffer, 2013). The legislation was specifically designed to improve quality and simultaneously cut the cost of care (Duska & Engelhard, 2013). Haas (2013) reported that the PPACA was enacted to implement health insurance reform to allow timely, affordable access to care and to enhance quality

and decrease costs of health care. Davis et al. (2010) studied payment and system reform initiatives and argues the PPACA has a fundamental impact on the health care system to add value to. In efforts to promote quality and efficiency, opinion leaders of health care support a reform of provider payment models that focus on physician and hospital remuneration for value and safety, not volume (Davis et al., 2010). Medicare and Medicaid have been impacted by the PPACA and specifically demonstrate the connection to quality and payment reform.

Policy makers put significant attention to the restructure of Medicare and Medicaid in efforts to improve the overall quality of care to patients. Ferman (2010) reported the ratification of revised Medicare and Medicaid policies includes key provisions intended to reform the delivery system. The Medicare and Medicaid policy "provisions include (a) higher payment for primary care physicians, medical homes, pilot programs for bundling and accountable-care organizations, (b) lower payments for preventable hospital readmissions and hospital-acquired conditions, and (c) the creation of the Center of Medicare and Medicaid Innovations" (Ferman, 2010, p. 58). In addition, provisions eliminate co-pays and deductibles for preventative services such as annual physicals for Medicare beneficiaries (Shaffer, 2013). Each of the above provisions have a connection to quality and the use of primary care services, which demonstrates the heightened awareness for primary care providers' readiness for health reform. Medicare and Medicaid beneficiaries can expect to see a focus on the quality of care they receive.

Medicare

In efforts to improve quality, provisions in the PPACA address Medicare payment reform. Duska and Engelhard (2013) reported the PPACA establishes significant changes in Medicare hospital payment policy in order to improve quality and value of care. In 2015, the PPACA will reduce Medicare payments by 1% for hospitals scoring in the top 25% rate of hospital acquired conditions (HAC) and requires that HACs be tracked and publicly reported (Duska & Engelhard, 2013). With the potential cuts to Medicare reimbursements, providers have already started to decrease the number of Medicare patients they care for (Spillman & Sgo Government Relations, 2011). Medicare patients in many instances have had to forego care as a result of providers' desire to cut back in their care for this patient population (Duska & Engelhard, 2013). Howard (2012) reported the PPACA does not cut Medicare benefits but rather focuses to reduce increased costs through a decrease in unreasonable payments to providers.

Health care reform involved specific attention to the use of Medicare services and the legitimacy of payment based on the quality of care provided. The Recovery Audit Contractors (RAC) is a Medicare program created to identify improper payments by conducting post payment reviews of Medicare Part A and B claims (Robin & Gershwin, 2010). The government intends to reduce waste, fraud, and abuse in Medicare spending (Inglehart, 2009). Robin and Gershwin (2010) argued providers should expect an increase in request for records from RAC and have the proper systems to manage reporting of the data. Medicare payments to providers must be accurate and reflect the actual care provided. If payments are not reasonable in terms of a correlation with the

care provided, overpayments will be returned to the Medicare Trust Fund. The PPACA specifically addressed methods that cut Medicare spending.

The PPACA introduced the creation of the Independent Payment Advisory Board (IPAB), tasked with the responsibility of identifying opportunities to cut Medicare spending. In 2014, the IPAB will form policy to reduce Medicare growth by 1.5% and concurrently improve the quality of care to Medicare beneficiaries (Filson et al., 2011). Elmendorf (2010) reported the IPAB will save a projected $13 billion between 2014 and 2020. Capretta (2010) argued the IPAB will rein in Medicare cost and potentially transition payment to focus on quality rather than quantity of services. These actions represent health care reform's focus to restructure payments to optimize quality of care. The PPACA also has provisions that have quality implications by the expansion of Medicaid. To improve quality, individuals must first have appropriate access to medical care.

Medicaid

Medicaid expansion has been considered as a component of the PPACA that will improve care through and increase in access to health insurance. The PPACA's primary purpose to expand Medicaid was to provide health insurance to millions of uninsured adults and children across the country (Duska & Engelhard, 2013). Each state has a considerable amount of autonomy to shape eligibility for Medicaid services, which has resulted in wide variations in the program from state to state (Cantor, Thompson, & Farnham, 2013). The PPACA has provisions to decrease Medicaid variation through

mandates that programs cover all individuals with incomes below 133% of the established poverty level (Cantor et al., 2013). This effort to improve quality through increased access was essentially blocked as the Supreme Court ruled in 2012 that states are not obligated to expand Medicaid services that will result in inevitable variations (Cantor et al., 2013). Duska and Engelhard (2013) argued the PPACA will not prove to be effective to increase access to care if states do not chose to participate in Medicaid expansion.

Medicaid has the potential to expand but the program also challenges providers due to low reimbursements for their efforts. The federal government is responsible for 50% to 76% of the cost of care for Medicaid beneficiaries, with support depending on each state's federal matching rate and its per capita income (Duska & Engelhard, 2013). The Kaiser Family Foundation (2010) reported that federal matching rates are lower for states that have higher per capita incomes. One of the major concerns with Medicaid is inadequate reimbursements that result in providers that drop out of the program and for which no obvious solution is apparent (Duska & Engelhard, 2013). If the numbers of providers with no desire to continue to take Medicaid patients increase, quality of care will have significant implications. Most notably, payment models connected to quality outcomes will be on the forefront and thus providers and organizations will need to be familiar with the changes.

Payment Models that Reflect Current Changes

The development and redesign of how physicians and health care organizations are reimbursed has been the primary focus of health care reform. The development and implementation of new payment models illustrates one of the most important provisions of health care reform and is considered the leading strategy of reform (Silverman, 2011). Financial incentives for performance and quality continue to grow in primary care (Scott, 2011). Physicians, hospitals, payers, and policy makers have a significant challenge ahead to manage the transition to new payment models primarily due to the confusion to select from numerous models (Silverman, 2011). The goal is to align payment with quality outcomes and hold providers accountable to provide optimal quality care. The challenges for organizations are the transition to the many models and attempt to keep quality in line with payment expectations. Shomaker (2010) argued in order for health care cost to decrease, the system must transition away from the traditional FFS payments that rewards providers for volume regardless of need, effectiveness or quality.

Fee For Service

Fee for service payment models reimburse for medical services through the use of volume as the primary indicator for payment. Silversmith (2011) argued the benefit of FFS is its focus to maximize patient visits, however, there is little or no incentive to deliver efficient care or prevent unnecessary care. Baron (2012) argued payment models that reward providers for quality of care instead of volume of care has the potential to yield improved care that patients want to receive. The American College of Physicians (2009) reported physician organizations and policy makers have argued FFS does not

take into consideration the full value of contributions from primary care providers. Primary care providers must be focused on efforts to improve quality as payment models shift to remuneration based on outcomes. Fee for service payment models do not take into account the total work primary care providers perform such as around care coordination to prevent hospital readmissions.

Jencks, Williams, and Coleman (2009) analyzed patient readmissions in the Medicare FFS program and reported Medicare beneficiaries are prevalent and costly with 20% readmitted within 30 days of discharge. Hernandez et al., (2010) reported quality of care for readmissions can be improved with better coordination of care. Orszag and Emanuel (2010) argued the FFS payment system does not provide much incentive because payment is connected to volume as opposed to outcomes and as a result, change needed to improve coordination of care is limited. The PPACA provides $500 million for organizations to manage care within 30 days of discharge and will reduce payments for hospitals with high risk-adjusted readmission rates (Orszag & Emanuel, 2010). Primary care providers will be tasked with assuring hospital readmissions are reduced and admissions alleviated by improving coordination of care post hospital discharge.

Pay for Coordination

Pay for coordination is a model designed to improve the quality of care delivery by allowing PCPs to coordinate services of care to ultimately prevent chronic disease exacerbation. The payment model is based on the patient's chronic health and care coordination needs and is intended to reduce unnecessary procedures and hospital visits

for care that can be managed by PCPs (Silverman, 2011). The advanced medical home model (AMH) is the concept used by primary care practices to coordinate care. The AMH assumes patient responsibility for (a) long term care needs, (b) new health problems, (c) to provide comprehensive care for issues that do not require a specialist, and (d) to coordinate care which require a referral outside the practice (Shomaker, 2010). Primary care practices have specific reimbursement opportunities that provide these coordinated services.

Payment for the coordination of services brings a different approach to payment models but is directly in line with health care reform's attempt to improve overall quality of care. Primary care providers that participate in the AMH model of coordinated services program will receive a global per-member-per-month capitation payment in addition to a supplemental care coordination payment (Shomaker, 2010). Reid et al. (2009) completed a study to analyze outcomes of the medical home model and reported the AMH model reduced emergency room visits by 29% and hospitalizations by 11% which improved quality of care at Group Health Cooperative in Seattle. The AMH model is currently under way and is sponsored by the Centers for Medicare and Medicaid Services (CMMS) and by insurers like CIGNA and United Health Care (UH) (Shomaker, 2010). Participation in the AMH model requires primary care practices to redesign their practice workflows to improve access, coordinated care, chronic disease management, and physician to patient relationships. Reimbursement opportunities are headed more into the direction of how providers perform and associated improvements in patient outcomes.

Pay-For-Performance

Pay-for-performance (P4P) has gained much attention as health reform attempts to put quality and outcomes at the forefront. P4P is an intervention of quality improvement that connects provider remuneration directly to achieved quality indicators and is considered one of the primary tools to support health care reform (Van et al, 2010). P4P systems continue to expand in primary care and has even experienced a rise in implementation internationally (Boeckxstaens, Smedt, Maeseneer, Annemans, & Willems, 2011). The primary purpose is to engage providers and organizations to improve quality of care as a result of financial incentives. There are varied conceptions from primary care providers around P4P payment models due to unintended consequences of the programs.

In order for P4P payment models to be useful, primary care providers must buy into the programs and conform their practices to the metrics at which quality outcomes are measured and reimbursed. McDonald and Roland (2009) argued unintended consequences of P4P is linked directly to changes in office visits due to an increased reliance on electronic medical records (EMR) to facilitate the delivery of higher numbers of performance measures. Provider discontent with P4P is the result of increased data input into the electronic medical records (EMR) for performance measures which is viewed as valuable time lost from the patient's visit. McDonald and Roland (2009) report physicians view the large numbers of data requirements in the EMR as a threat to the physician-patient relationship and professional autonomy. P4P focuses on outcome

measures for reimbursement while other programs such as bundled payments targets quality by a decrease of variation in services.

Bundled Payments

The concept of bundled payments is outlined in the PPACA as a method of payment reform designed to restructure reimbursement for health care services rendered. Shay and Mick (2013) reported the PPACA outlines bundled payments that permit one provider to receive a single payment for all services rendered throughout an entire episode and divide the payment with each of the other providers based on service provided. Each entity will receive a portion of the payment and thus are equally responsible for the outcomes, which improve efficiency. It is anticipated that episode-based bundled payments will produce substantial Medicare savings (Weeks, Rauh, Wadsworth, & Weinstein, 2013). The PPACA required the Department of Health and Human Services (HHS) to implement the National Pilot Program on Payment Bundling effective January 1, 2013, which includes acute care and post-acute care services provided to Medicare beneficiaries (Shay & Mick, 2013). Bundled payments are intended to bridge quality gaps in care through effective communications and coordination of care between hospitals and PCPs, particularly to prevent hospital readmissions.

Models of bundled payments specifically address quality of care post hospital discharge through an integrated approach where acute and post-acute care entities coordinate care together. PCPs are directly involved in the care coordination with patient

follow ups in the office to prevent hospital readmissions. Giles (2011) reported bundled payments requires a cultural change for hospitals, physicians, and other providers where success is highly depended upon a team oriented culture with open communication. Larkin (2010) argued hospitals which participate in the pilot bundled payment program are at risk for the cost and quality of care delivered in post-acute care entities such as the PCP's office. Due to increased accountability and shared responsibilities, it will be important that hospitals and PCPs work together to coordinated care if maximum reimbursements are to be achieved. A collaboration of efforts is essential as health reform transitions to payments based on the value of care.

Value Based Purchasing

Health care organizations have put significant attention on the value of care delivered to patients as efforts of health reform focus payment on outcomes. Karash (2013) reported the transition to a health care system based on value rather than volume is the most important objective for health reform as a value-based payment system yields safer care and cuts unnecessary costs. Dowd (2013) reported the PPACA has provisions to slow spending and get more value for the money spent on health care to include payment reductions for outcomes that don't meet defined quality targets, creation of provider accountability systems such as accountable care organizations (ACOs), and demonstrations of bundled payments. The change in how health care systems and providers are reimbursed based on value has resulted in a significant focus for health care organizations to alter how care is delivered. It is important to acknowledge that health

care reform has shifted focus to value-based payments as opposed to previous volume models of reimbursements and organizations must transform care delivery to maximize payment. The focus on value-based payments will have significant implications on how PCPs practice (Zimlich, 2013).

The practice of PCPs will undergo significant changes as health care reform shifts the focus on value and outcomes as the primary indicator for payment. Bendix (2013) argued that due to changes in the nation's private insurance market that has shifted reimbursement based on quality and outcomes, PCPs will need to demonstrate more evidence of value to payers by way of the quality of care provided. The transition from a volume-oriented health care system to one based on quality and efficiency requires coordinated and patient centered care (Berwick, 2013). PCPs will be under great pressure to perform in order to maximize payment as the PPACA and private payers hold PCPs accountable for care coordination and patient centered efforts of improved communication to close gaps in care. The recent changes in payment models based on quality and outcomes has been the center of debates for several years and was solidified with the 2010 passing of the PPACA.

Primary Care Quality Initiatives

The PPACA is focused on components to improve overall quality of care with a specific emphasis on initiatives in primary care. Health care expenditures continues to rise and the government has proposed several initiatives to decrease cost through primary care quality initiatives. Calman, Golub, and Shuman (2012) reported health care reform

promotes (a) comprehensive, coordinated and continuous primary care, (b) preventive care, (c) minimization of duplicated services, and (d) enhanced coordination of care, which are all core principles of primary care. Primary care is a key component to improve outcomes as many of the aforementioned components to improve quality is focused on initiatives carried out in primary care practices. The federal government has put specific attention to grow the number of primary care practices to serve underserved populations.

Federally Qualified Health Centers

Health care reform promotes the use of federally qualified health centers (FQHCs) to improve quality of care and particularly in underserved populations. Federally qualified health centers have been known to be a key component to the primary care safety-net and is highly regarded as an important initiative for the Obama Administration, with a $14.5 billion investment from Congress (Adashi, Geiger, & Fine, 2010; U.S. Department of Health and Human Services, 2011). Calman, Golub, and Shuman (2012) reported FQHCs are unique and beneficial to underserved populations due to the interdisciplinary team of primary care providers, nurses, health educators, social workers, outreach workers, and transportations services which are all key to provide comprehensive quality care. Federally qualified health centers provides access to care to optimize quality as the care is comprehensive and promotes a wide range of primary care services to close gaps in care. Fiscella (2011) argued FQHCs' role to strengthen the primary care safety net is important as millions of people become insured as a result of the PPACA's insurance expansion initiatives. Other initiatives have been

rolled out with the PPACA that focus on quality outcomes such as the patient-centered medical home (PCMH).

Patient-Centered Medical Home

The PCMH is an initiative targeted to improve quality of care in primary care practices and incentivize organizations for its participation through payment models focused on defined quality outcomes. In the PCMH model, PCPs and nurses work collaboratively to personalize, prioritize and integrate care to improve the health of whole people, families, communities, and populations (Strange et al., 2010). Calman (2013) argued the PCMH model has potential to optimize patient care and improve outcomes, yet there is much to learn about the implementation of the model and overall impact on patient care. The PCMH model requires the team of providers and nurses to identify gaps in care and improve access and communication to patients in order to maximize payment incentives initiated in the PPACA to improve quality. Provisions of the PPACA address specifics of the PCMH model to maximize PCP payment based on the implementation of PCMH and quality outcomes.

The PCMH model of care is a primary care initiative recognized in the PPACA as a method to improve overall quality of care by the connection of payment to outcomes. Mechanic and Altman (2010) reported the PPACA includes provisions of the PCMH to test innovative payment models designed to reduce expenditures and enhance quality of care. Payment provisions include reimbursements for care coordination, care management, and medical consultation outside of the tradition face-to-face visit to

include (a) case-mix differences, (b) use of clinical technology for quality improvement, (c) reduced hospitalizations, and (d) achievement of quality targets (Rittenhouse, Thom, & Schmittdiel, 2010). The model of care under the PCMH provides financial recognition for quality which is intended to close gaps in care and particularly around chronic disease management through improved coordination of care. The role of case management is instrumental to improve care coordination and to close gaps in access.

Case Management

The roll out of the PPACA directly involves the work of social workers. Darnell (2013) analyzed the PPACA's quality initiatives that focused on the use of navigators as an approach to social work case management in situations of insurance enrollment in Medicaid or exchanges and to maximize efficient use of benefits. An important component to improve the quality of care and coordination is to first establish a gateway into the health care system. Navigators are social workers that will play a role to determine the overall success of the PPACA by the enrollment of the uninsured in eligible health insurance programs (Darnell, 2013). Sommers et al. (2012) summarized the take-up rates among Medicaid adults, which make reference to the number of people that actually get enrolled. Studies on take-up rates have demonstrated that the average is 32% to 81% but in less biased studies, averages are between 32% and 52% (Darnell, 2013). The variation of take-up rates illustrates the challenge navigators experience as they attempt to enroll eligible populations and improve quality through access, which is also achieved through health homes.

Health Homes

To improve the quality of care provided to patients that require primary care, the PPACA has provisions to incentivize organizations for outreach work in health homes. Health homes are achieved through providers that demonstrate coordinated primary care, mental health, and substance abuse with the objective to improve care to high risk patients at lower cost (Calman, Golub, & Shuman, 2012). The health home model utilizes a team of care managers or coordinators to reach out to patients in their homes or accompany in specialty appointments with anticipation to bring them into primary care (Calman, Golub, & Shuman, 2012). The primary objective of health homes is to improve gaps in care and specifically in chronic disease management. Primary care providers have opportunity to maximize payment through care coordination and the ability to engage patients in their care to encourage office visits. The health home quality initiative demonstrates PCPs responsibility to improve care outside of the practice but also is a system that highlights the PPACA's goal to bring accountability to health care.

Accountable Care Organizations

The PPACA is highly regarded as a law intended to implement initiatives to improve quality by way of provider and organizational accountability. Druss and Mauer (2010) reported the PPACA holds providers responsible to care for groups of patients through the organization of hospitals, specialists, and PCPs as accountable care organizations (ACOs). Accountable care organizations are a group of providers whose mission is to manage the full continuum of care and be accountable for quality outcomes for a defined population (Rittenhouse, Shortell, & Fisher, 2009). Accountable care

organizations provides reform in payments for health care services to incentivize organizations to participate in quality improvement initiatives to provide better care at lower costs, with the objective to generate higher reimbursements (U.S. Department of Health and Human Services, 2012). Health reform's primary objective is to improve overall quality of care to ensure care is timely, accurate, and most importantly holds providers and organizations accountable to patient outcomes. An important component to a successful ACO is the coordination and access of primary care services.

In order for quality of care to improve through the use of ACOs, PCPs will need to play a key role to ensure primary care is coordinated to align with quality expectations. The U.S. Department of Health and Human Services (2010) reported PCPs are responsible for patients' appropriate use of medical care through accessible primary and preventive health services to prevent emergency room visits and manage chronic illnesses. Rittenhouse, Shortell, and Fisher (2009) argued the organization of providers to improve care through ACOs will not succeed without a strong foundation of PCPs that perform at high standards. Primary care is the gateway to health care and it is important that organizations and PCPs work to ensure key preventive screens and chronic disease management is achieved in order to maximize the benefits of ACOs. Primary care providers will be responsible and will need to report on quality metrics like hospital readmissions and the frequency of patients' screening tests and check-ups (Accountable Care Organizations, 20011). The PPACA has provisions to share the savings that result in improved cost effective care.

Participation in ACOs result in payments outlined in the PPACA that reimburses through a shared savings program (SSP) for quality achievements. In the SSP, Medicare calculates an expected expenditure of the total patients cared for by the ACO and if total spend is less than expected coupled with achieved quality targets, the ACO will receive a portion of the savings as a bonus (Devers & Berenson, 2009). DeLia, Hoover, and Cantor (2012) reported the savings bonus is important to ACOs as the money is needed for relevant start-up and operational costs to include information technology, physician extenders, and patient navigators. The intent of the SSP is to promote accountability for care provided to Medicare beneficiaries and redesign care processes that focus on high quality and efficiency (Medicare Program, 2011). The transition to an ACO requires organizations to invest substantial time and resources to meet patient needs.

Meaningful Use

The PPACA has outlined specific meaningful use (MU) objectives intended to improve the quality of care provided to patients. Meaningful use objectives are to improve care coordination and the quality, safety, and efficiency of care to patients (Calman, Golub, & Shuman, 2012). The PPACA provides nearly 40 billion in financial incentives for the achievement of advances in health care processes and outcomes (Blumenthal & Tavenner, 2010). Providers will need to attest to the use of EMRs to improve patient outcomes by way of care coordination and documentation of appropriate health information. DesRoches, Audet, Painter, and Donelan, (2013) argued the proportion of providers who are able to meet MU criteria and manage patient populations

through the use of EMRs is undetermined. Meaningful use has potential to improve patient outcomes if providers successfully attest to quality objectives. The challenge for MU as an identified quality initiative is the unknown over whether or not PCPs will comply and maintain consistent standards of EMRs use to manage chronic disease.

Electronic Medical Records and their Role in Primary Care

The use of EMRs as a methodology to improve the quality of primary care continues to increase. Health care reform has provisions which rewards for improved coordination of care through the use of EMRs. Calman, Hauser, Lurio, Wu, and Pichardo (2012) studied the potential of more effective use of EMRs between health departments and PCPs to improve population health in communities. The study evaluates the use and benefits of EMRs between The New York City Department of Health and Mental Hygiene and The Institute for Family Health. According to the study (Calman et al., 2012), public health departments must consider the use of EMRs in primary care settings when new population health guidelines are developed and PCPs will need to align their EMRs with public health priorities. It is important that care coordination between public health departments and PCPs are parallel if quality of care goals are to be achieved. Electronic medical records are a key component used by payers to determine levels of quality achieved and the appropriate reimbursements. Patient participation in the use of EMRs is also a goal of health reform's objective of improved quality of care.

The use of EMRs goes beyond communication from provider to provider but also from patient to provider. The implementation of EMRs in primary care settings has

potential to improve care and communication through an electronic patient portal. Patients are able to communicate directly to their PCPs through this electronic system with anticipation of improved quality of care and communication. Ancker et al. (2011) studied participation rates of 74,368 patients seen over a two year period with access to an electronic patient portal. The study revealed 16% of the patients received an access code to the electronic patient portal and of that, 49% actually used the account (Ancher et al., 2011). In order for quality of care to improve, it is important that patients are active in their care. Providers and health care organizations are held accountable to achieve identified quality metrics with payment models focused specifically on quality outcomes. The potential to not meet quality objectives as a result of poor patient compliance and active participation in care plans is a concern of many PCPs and health care organizations.

Quality Reporting with Statistical Analyses

With the many initiatives of health reform which focus on quality outcomes, providers will need to be prepared for increased scrutiny on care delivery as requirements for quality reporting are rolled out. The Physician Quality Reporting System (PQRS) is a Centers for Medicare and Medicaid Services program which tie reimbursement to quality outcomes, provide incentive payments for successful quality reporting, and financial penalties for providers with unsatisfactory reporting of clinical outcomes (Zimlich, 2013). The PPACA mandates all eligible providers to participate in the PQRS in 2013 or be subject to a 1.5% financial penalty in 2015 and a 2% penalty in 2016 and beyond (Painter

& Painter, 2013). The reporting of quality measures has come with increased provider concern as selected measures remain questionable in terms of its denotation of quality.

The potential for quality reporting of outcomes to not align with providers' perception of quality yields challenges in the transition to quality reporting. A study (Cohn et al., 2013) analyzed 12 quality measures specific to gynecologic oncology and evaluated the effectiveness of quality reporting to determine if the appropriate quality measures were identified for the patients. Cohn et al. (2013) reported despite mandatory reporting of quality measures, uncertainty still exist in appropriate quality measures for gynecologic patients with wide variation of quality metric rankings due to provider and institutional factors. Providers and organizations will experience payment reductions due to poor quality reporting of patient outcomes. Provider consensus on appropriate quality measures is controversial as providers' medical care will be highly scrutinized for quality achievements and alignment with payment requirements.

Summary

The PPACA has required PCPs and health care organizations to increase their attention on quality outcomes. Provisions of the law mandates payment reform to focus on quality of care as opposed to the volume of care provided. The PPACA requires PCPs to experience many changes in medical practice which focus on closing gaps in care through the improvement of chronic disease management (Peccoralo, Callahan, Stark, & DeCherrie, 2012). The primary objective of health reform is to improve quality and decrease the cost of care (Duska & Engelhard, 2013). To achieve an improvement in the

quality of care provided, payment models have changed to hold providers and health care organizations more accountable to patients' care. Many programs to improve quality of care have been outlined and organizations continue to ramp up participation in quality initiatives. The use of EHRs will aid in quality improvement as provider documentation and patient communication are enhanced. Providers will also be required to participate in the reporting of quality outcomes or be financially penalized.

Conclusion

The literature provides evidence that the quality of care provided will be the primary focus of PCPs and health care organizations over the next several years. The PPACA has been highly regarded as the component to reestablish primary care in the United States (Goodson, 2010). The PPACA has heightened the awareness of how instrumental primary care will be to close gaps in care and improve overall quality. It is very clear in the literature that payment models with focus on quality will be the force to drive improved outcomes. If care does not meet specified quality measures, reimbursement will subsequently decline. Providers' perspective on the denotation of quality metrics and whether or not care is improved measurably with the transition to quality payment models has not been determined. This study will examine the perspectives of providers on quality definitions and the challenges ahead with the current quality measure mandates. This study will also determine if care is improved measurably based on the viewpoints of the providers.

Chapter 2 provided a literature review of the transition to payment models that focus on quality outcomes and the implications on PCPs. The literature focused specifically on various quality initiatives and how PCPs and health care organizations have and will adjust to maximize payment. Chapter 3 presents the methodology that will be used to evaluate the study.

Chapter 3: Research Method

Introduction

This study will examine the transition of PCPs to new payment models with emphasis on quality outcomes and determine if care is improved measurably. Under provisions of the PPACA, PCPs are challenged with the responsibility to improve patient outcomes through the connection of patient outcomes to reimbursement potential. The perspectives of providers will be evaluated to determine the effectiveness of the connection of reimbursement to quality outcomes under provisions of the PPACA. Chapter 3 will evaluate the research methods to be used in the study. The chapter specifically examines (a) the research design, (b) role of the researcher, (c) study methodology, (d) issues of trustworthiness, and (e) ethical procedures.

Research Design and Rationale

In order to understand provisions of the PPACA targeted to improve patient outcomes, this study will evaluate specific practice adjustments of PCPs which are anticipated to improve the quality of care delivered. New payment models under the PPACA are aligned with outcomes of patient care. This study will analyze quality metrics implemented in primary care practices in order to improve care and maximize payment. Primary care providers are key contributors of the PPACA's objective to improve care and decrease cost. The management of chronic disease is an essential component to maximize reimbursement as new payment models focus on patient outcomes as the key driver for payment. A qualitative research design will be used to

evaluate PCPs' perspective on transitions to new payment models with focus on quality metrics and if care is measurably improved.

This study will evaluate the perspectives of PCPs on identified quality metrics under the PPACA which are intended to improve patient outcomes and maximize payment. In order to determine the effectiveness of payment models with focus on quality, PCPs must account for how medical practices have changed to aligned with new provisions of quality standards. To understand the transitions to new payment models, a qualitative approach was selected to allow for interviews and surveys to take place with PCPs. The interviews will focus on provisions under the PPACA to implement quality metrics and hold providers accountable to patient outcomes or be subject to payment reductions. A phenomenological method will be used to understand the lived experiences of providers on their transition to new payment models with focus on quality outcomes. A qualitative approach best fits the desired outcomes of the study specifically due to the ability to collect data through interviews. The study will need the flexibility of open ended questions and provider interpretations of what denotes as quality patient care. A quantitative approach will not yield such flexibility to collect interview type data.

Research Questions

The following research questions will guide this study:

RQ1: What quality metrics are primary care practices of health care organizations implementing to improve patient visits?

RQ2: What are the concerns from physicians with having to meet the quality provisions of the PPACA?

RQ3: Are physicians concerned that focusing payment on quality will decrease compensation due to potentially limiting the number of patient appointments?

RQ4: How will quality metrics impact providers' ability to see more patients in less time?

RQ5: Are physicians in agreement that reimbursements should be based on meeting quality metrics?

RQ6: Should quality measures play a role in employed physician contracts?

RQ7: Are physicians experiencing improvements in the quality of care being delivered as a result of quality initiatives?

Role of the Researcher

I will be directly involved in the collection of data for this study as the interviewer. Interviews will be conducted with PCPs through a series of questions related to the PPACA and the transition to new payment models focused on quality metrics. I will conduct the interviews in the providers' practices to allow for a comfortable environment. An overview of the research purpose will be explained to the participants with opportunities to ask questions of clarification prior to the interviews. I will provide background on my professional experiences and any personal connection to the study. There will be professional relationships between myself and the participants as

employees of the same health care organization. In some instances, the participants may be providers within practices at which I provide administrative oversight. I will be objective and reassure the participants of the confidentiality of their responses to alleviate ethical concerns.

Methodology

The population for this study is PCPs directly impacted by provisions under the PPACA to improve care through new payment models with focus on patient outcomes. Primary care providers are challenged to improve chronic diseases and overall coordination of care. New payment models focused on quality outcomes require PCPs to be actively engaged to close gaps in patient care and improve outcomes. Primary care operations are changed as PCPs align their medical practices with provisions to improve care under the PPACA. In order for payment to be maximized, PCPs must adhere to new standards of care which are specifically focused on identified metrics of quality. This study is centered on the work of PCPs and their transition to new payment models focused on the quality of primary care provided (Bendix, 2013).

This study will use a purposeful sampling strategy of PCPs directly impacted by the transition to new payment models focused on quality outcomes. Purposeful sampling provides opportunity to select PCPs who inform the study through their personal experiences. Primary care providers are the main drivers of disease and wellness prevention. The study focuses on the shift to quality payment models and PCPs serve the purpose to understand the transitions. Purposeful sampling enables participants to be

selected that are familiar with provisions of the PPACA that provides guidance to providers on new measures of quality and payment reform (Palinkas, 2013).

Participants will be selected for this study based on their medical credentials and experience. This study will take place in corporate primary care practices. Providers that have completed medical school and residency in Family, Pediatric, or Internal Medicine will be the targeted participants. It is important for the participants to have completed training in one of the primary care specialties in order to capture providers familiar with primary care practices and workflows. The study will target PCP participants with at least two years of experience to understand the transition to quality focused payment models and the implications on patient outcomes. Primary care providers are the drivers of chronic care management and will be more informed on new provisions to transform care with greater emphasis on quality metrics and to maximize payment. Nurse Practitioners are not required to report quality outcomes under the PPACA and therefore are excluded from the study as a primary care provider.

This study will use nine PCPs that are currently in medical practice for a corporate health system. The sample size was specifically selected to have a comprehensive analysis of the study participants. The participants will consist of three each of the following primary care specialties: family practitioner, internist, and pediatrician. Each will bring a unique perspective to the transition to quality payment models and comprehensiveness to the study in terms of subject matter. Providers with leadership experience will also be recruited as participants in order to obtain a PCP

perspective from an administrative standpoint. The sample will be identified in Richmond Virginia based on specialty and specifically recruited through one on one discussions about their interests to participate in the study. The purpose of the study will be reviewed with each potential participant.

Data Collection

I will be the key instrument to collect data through multiple interviews with each participant. Each of the interviews will be audiotaped and later analyzed for key themes and data to support the study. Permission to audiotape will be obtained prior to the interviews. Interviews will be conducted in physician offices to ensure each participant is comfortable. The interview protocol will be reviewed with participants prior to questioning. Data will be collected through a series of opened-ended questions. The interviewee will have the opportunity to elaborate and ask questions of clarification on topics throughout the interview. Data will be inputted in NVivo software for review and analysis of various themes and key words important to the study.

Data Analysis

The interview notes will be analyzed within 24-48 hours after the interview. Notes will be reviewed for specific data relevant to the study. The purpose of this study is to understand PCPs' transition to payment models with emphasis on quality measures and determine if care is improved measurably. Interview questions will be focused specifically on the perspectives of PCPs and the implications of health reform on their medical practices. After each interview, the notes will be reviewed prior to exiting the

interview to ensure all questions were answered. Data will be coded in NVivo to analyze for themes. I will interpret the data based on participants' perspectives and not incorporate my own viewpoints. I will organize the data by similar themes in order to evaluate if a pattern is more consistent than others.

The data analysis will include a detailed review of the perspectives of PCPs and be compared to the literature review. I will evaluate the various payment models focused on quality outcomes from the literature review and determine if PCPs have incorporated changes to practices based on provisions under the PPACA. Transitions in care will be analyzed for alignment with new quality provisions. A determination of PCPs' perspective on improved care will be analyzed for its alignment with provisions to improve care under the PPACA

Issues of Trustworthiness

I will conduct member checks to ensure the accuracy of data collected. Participants will be selected, based on need to clarify themes, for follow-up interviews. The follow-up will give participants the opportunity to respond to various themes from the data collection. I will recruit a subject matter expert on health care reform and the transition to quality payment models for peer review of the data if there is a need to clarify discrepant themes or misunderstandings of the subject. The peer review will primarily be used to evaluate data for accuracy and any obvious evidence that may need to be addressed. Study participants will be recruited from at minimum four different physician practices to ensure variation in participant selection.

Each interview transcript will be analyzed carefully for possible misconceptions of participants' responses. The data audit will include a review of each response and if any component is misunderstood, I will follow-up with the participant to alleviate misrepresented conclusions. Keywords and codes inputted in the data analysis process will be double checked and compared to the data collected. These processes will be used to confirm dependability of data collected.

Ethical Procedures

For this study, all participants will be asked to sign an informed consent form prior to engagement in interviews (Appendix C). The study purpose and interview protocol procedure will be reviewed with each participant when the consent form is signed. Data collection will consist of face to face interviews with open-ended questions. Each participant will be reassured that their responses and names will remain confidential. It will be explained to each participant that interviews may be stopped in the event it is requested. Permission will be obtained by the Institutional Review Board (IRB) prior to any data collection. Data will be analyzed accurately to align with interview responses and under no circumstance will misrepresentations exist. All data will be held confidentially in a secure location and discarded after five years.

Summary

Chapter 3 provided a description of the qualitative research design and rational for the phenomenological approach. Research questions and methodology were presented with a detailed description of the role of the researcher throughout the study. Data

collection procedures and analysis were explained along with detailed descriptions of activities. Issues of trustworthiness and ethical considerations were also described in detail. Chapter 4 will present the results and findings.

Chapter 4: Results and Findings

The purpose of this qualitative phenomenological study was to analyze the transition of primary care to new quality focused payment models. The study determined, through the perspective of PCPs, if care was improved as a result of increased focus on quality metrics. Research questions that guided the study were as follows:

RQ1: What quality metrics are primary care practices of health care organizations implementing to improve patient visits?

RQ2: What are the concerns from physicians with having to meet the quality provisions of the PPACA?

RQ3: Are physicians concerned that focusing payment on quality will decrease compensation due to potentially limiting the number of patient appointments?

RQ4: How will quality metrics impact providers' ability to see more patients in less time?

RQ5: Are physicians in agreement that reimbursements should be based on meeting quality metrics?

RQ6: Should quality measures play a role in employed physician contracts?

RQ7: Are physicians experiencing improvements in the quality of care being delivered as a result of quality initiatives?

This chapter provides information relevant to collection of the data. The settings where interviews were conducted are provided. Specifics on the demographics of participants are presented. This chapter also provides a detailed review of the data collection to include sample size, data collection process details, and unanticipated variations and circumstances encountered in the data collection. An analysis of the data is included. Evidence of trustworthiness and study results are also discussed.

Setting

The interviews were conducted in the participants' medical practices. Six of the 9 interviews took place in the physicians' private offices. Three of the interviews were conducted in the medical practice conference rooms. Participants provided their preference in regards to where the interviews would take place. Participant selection of interview locations provided a more relaxed setting. Challenges evolved as a result of collection of data in the physicians' medical offices. Four of the 9 interviews experienced interruptions as medical staff personnel had questions for the physicians. The interruptions required physicians to pause in their thought processes, which may have influenced study responses. Five of the 9 interviews also started late due to the physicians finishing up their clinic schedule. One physician appeared to be in a hurry during the interview while the other 8 participants did not have an urgency to finish.

Demographics

The study participants consisted of 9 PCPs directly impacted by the transition to quality focused payment models. Each of the participants had clinical experience with

quality initiatives designed to achieve optimal reimbursement for medical services. Participants included three internists, three pediatricians, and three family practitioners. Seven were female and two male participants. The years of experience in medical practice ranged from 4 to 29 years. The participants were all directly employed by the health care organization. Seven participants had previous experience in private practice and were able to compare quality focused initiatives to a corporate health care system. Two of the physicians never worked in private practice and were only familiar with corporate systems.

Data Collection

Data were collected from nine primary care physicians through an interview process. Each interview was conducted in person on an individual basis. Group interviews were not conducted. Interview locations were at the participants' medical practices in order to facilitate a comfortable interview environment. Seven interviews were conducted in different individual practice locations. Two of the interviews took place at one practice location as the physicians practiced in the same medical practice group. The two interviews were separate and took place on different days and times. The sequence of interview questions was consistent for each interview session. Participants only had one interview conducted. The duration of each interview varied and ranged from 35 minutes to 50 minutes. Participants expected a 30 minute to 45 minute interview and any exceeding the time allotted was a result of the participants' request to add additional comments.

Each interview was audiotaped at the permission of the participants. Data was hand written throughout the interviews. After each interview, data was analyzed for accuracy against the audiotapes and within 24-48 hours of the actual interview. Each participant was associated with a number, which served as the identification. Participant numbers ranged from one to nine. Analysis of data included the associated participant numbers in order to correctly identify the appropriate interview data. Data was analyzed for various key words and themes relevant to the study. NVivo software was then used for data input and analysis of similar themes and categories.

Data collection was conducted with no variation in procedures from the initial plan. Each participant received a thorough review of the research protocol prior to collection of data. All interviews were audiotaped with participant consent and low level of concern. Participant names were excluded from interview sessions; and participants were instructed to reframe from utilization of direct name identification throughout interviews. All questions were clearly understood by participants throughout interviews. Each participant appropriately asked for clarification of questions as needed, which was a low level of clarifications.

All participants were very comfortable as interviews were conducted. Four participants experienced interruptions from their medical staff teams and resulted in minor delays in their response to questions. One physician was in a hurry as evidenced of quick responses and several glances at the time. All other interview participants did not show signs of the need to hurry and patiently responded to questions. The research

topic appealed to all the participants as demonstrated by their attentiveness to the questions and eagerness to participate in the study. All participants displayed a polite demeanor throughout each interview and voluntarily offered to participate in future research studies.

Data Analysis and Results

Categories were developed based on the predetermined research questions. Themes emerged out of each category through analyses of interview responses. Raw data were organized, reviewed for themes, and input into NVivo software to analyze similar themes and key words. Codes were created from interview responses and assisted in development of the themes. Themes emerged and were appropriately placed under each category. Each category corresponded to an interview question and was used to develop codes and run word frequency queries. Similar themes emerged for each category and served as the basis for the data analysis.

Various codes were developed to organize the data into similar themes and categories. Codes included: need more defined pediatric quality metrics (ND); expectation is not clear on how to achieve quality metrics (EC); chronic disease management of blood pressure, diabetes, and cholesterol (CD); metrics should not be based on patient outcomes (MS); quality outcomes vary with different patient populations (QO); quality of patient to provider relationship decreasing (QP); less money and more work (LM); were concerned compensation will decrease (YC); will see less patients (WS); more efficient with EMR quality initiatives but too many steps (ME);

reimbursement should not be based on outcomes (RS); cannot control patient behavior (CC); not evidence of providers' clinical work (NE); metrics should not be in physician contracts (MN); and no improvements in patient quality (NI).

Themes emerged for quality metrics that addresses RQ1 are included in Table 1 below:

Table 1.

Themes Regarding Quality Metrics (RQ1)

Quality Metrics Themes-Category 1 (C1)	Respondents
Expectation is not clear on how to achieve quality metrics	*N* = 6
Need more defined pediatric quality metrics	*N* = 5
Chronic disease management of blood pressure, diabetes, and cholesterol	*N* = 4

The Quality Metrics category, C1 provides participants' responses to quality metrics they understand to be providers' responsibility to improve patient outcomes. The primary theme emerged from the category was the participants' perspective that the expectation of the organization is not clear on how to achieve quality metrics. Six out of

9 participants reported the need for more clear expectations from the organization on how to achieve quality metrics.

Participant # 2 reported, “I am not sure I understand how to meet some of the quality metrics asked of me.”

Similar to that response was participant # 7, who said, “there are so many clicks in the medical record, that I do not know which ones will meet the measure.”

Also participant # 3 stated, “I need more education on how quality metrics have been defined and what my role is.”

The second theme emerged from C1 is PCPs’ perspective that pediatric quality metrics need better definitions by the organization and government. Five out of 9 participants reported that pediatric quality metrics are a major responsibility of PCPs, but the metrics have not been clearly defined.

Participant # 7 reported, “the organization needs to do a better job at defining pediatric quality metrics.

Participant # 4 also provided a similar response, stating, “I don’t think the government has made it clear to organizations what doctors’ responsibility is to meet pediatric quality.”

Continuing to speak to the need for clear pediatric quality metrics, participant # 8 said, “the organization’s focus seems to be more on adult quality metrics, but I care for pediatric patients too.”

The third theme emerged from C1 is participants' perspective that PCPs are responsible for chronic disease management of blood pressure, diabetes, and cholesterol. Four out of 9 participants reported they are individually responsible for quality outcomes of chronic disease management.

Participant # 7 said, "I feel I am responsible to improve chronic diseases, like high blood pressure and diabetes."

Participants # 2 and 9 also reported their responsibility to improve outcomes with blood pressure, diabetes, and cholesterol management.

Themes emerged for quality metric concerns that addresses RQ2 are included in Table 2 below:

Table 2.

Themes Regarding Quality Metric Concerns (RQ2)

Quality Metric Concerns Themes-Category 2 (C2)	Respondents
Metrics should not be based on patient outcomes	*N* = 7
Quality outcomes vary with different patient populations	*N* = 6
Quality of patient to provider relationship decreasing	*N* = 5

The Quality Metric Concerns category, C2 provides PCPs' perspectives on their concerns with having to meet quality metrics. The primary theme emerged from the category is quality metrics should not be based on patient outcomes. Seven out of 9 participants reported concern that quality metrics should not be developed based on patient outcomes.

Participant # 6 said, "I should not be held accountable to patient outcomes, but to the care plan I provide."

Participant # 8 also reported, "I cannot control what my patients do after they leave the office, thus should not be held responsible based on their individual health outcomes."

Similar to participants # 6 and 8, participant # 2 reported, "the current system is not fair because I am being held responsible for patient outcomes that I cannot control."

Participants # 3 and 5 also provided similar responses of concern that quality metrics should not be based on patient outcomes.

The second theme emerged from C2 was participants' perspective that quality outcomes will vary with different patient populations. Six out of 9 participants reported concern over disparities in quality outcomes with different populations of patients.

Participant # 5 reported, "patients that can afford medications will have better outcomes, so I am already at a disadvantage with a lower socio-economic population of patients."

Participant # 7 said, "I care for an older patient population; so, my quality outcomes will reflect sicker patients compared to doctors that have younger and healthier patients."

Participants # 2 and 3 also reported concern with available resources for patient populations that are poor and thus impact patient outcomes.

The third theme emerged from C2 was concern of decrease in quality of the patient to provider relationship as a result of increased focus on quality initiatives. Five out of 9 participants responded with issues related to the relationship with their patients.

Participants # 2, 4, 5, and 6 reported that more time was spent navigating through the medical record to meet quality metrics than communicating with the patient.

Participant # 3 specifically said, "I have a thousand unnecessary things to do with these quality metrics before I ask the patient what's wrong, and that's not good relationship building with patients or representative of high quality."

Themes emerged for provider compensation that addresses RQ3 are included in Table 3 below:

Table 3.

Themes Regarding Provider Compensation (RQ3)

Provider Compensation Themes-Category 3 (C3)	Respondents
Concerned compensation will decrease	*N*= 9

Less money and more work *N*=7

The Provider Compensation category, C3 provides participants' perspective on concern with individual compensation as a result of additional quality metric responsibilities. The primary theme emerged from the category was PCPs' response that compensation will drop as a result of additional steps in care through implementation of quality initiatives. Nine out of 9 participants all responded, "yes" to concern of declining compensation.

Participant # 5 said, "yes my patient appointments must decrease because I cannot keep up with these new quality metrics, which means my compensation will decrease."

The other eight participants all provided similar responses, acknowledging seeing less patients with a decrease in compensation.

The second theme emerged from C3 was PCPs' perspective of less money and more work. Seven out of 9 participants reported quality initiatives have increased work and consequently compensation.

Participant # 3 said, "I have been required to do more work with all of these quality metrics; yet, my compensation is dropping because I have to see less patients to get the work done."

Participant # 4 responded, "I am giving the same care as I have always done and now I have more work and less money due to a decline in my productivity."

Participant # 5 also gave a similar response and said, “I cannot get all these quality metrics completed in the patients’ room so I am taking work home all the time with no additional compensation.”

Themes emerged for efficiency that addresses RQ4 are included in Table 4 below:

Table 4.

Themes Regarding Efficiency (RQ4)

Efficiency Themes-Category 4 (C4)	Respondents
Will see less patients	*N*= 8
More efficient with EMR quality initiatives but too many steps	*N*=6

The Efficiency category, C4 provides PCPs’ perspective on their efficiency and ability to see more patients with increased focus on quality initiatives. The primary theme emerged from the category was the perspective that quality metrics will result in PCPs seeing less patients. Eight out of 9 participants reported their visit volume will decrease as a result of additional quality metric responsibilities.

Participant # 6 reported, “I understand the idea of improving quality, but there is no way I can manage my same patient load and do all these extra quality initiatives.”

Participant # 8 provided a similar response saying, “my patient visits are decreasing because of the need to do quality metrics.”

Participant # 1 said, “These metrics are overwhelming which means less patients will get seen.”

In addition, participant # 4 responded, “I am now less efficient, which means I must see less patients in order to keep up with documentation.”

The second theme emerged from C4 was PCPs’ perspective that they are more efficient with EMR quality metrics, but there are too many steps. Six out of 9 participants reported EMR documentation expectations are too cumbersome.

Participant # 3 said, “this system has too many steps to call it quality care.”

Participant # 4 reported, I am definitely more efficient due to alleviating handwriting, but the EMR has too many clicks which slows me down.”

Participant # 6 also provided a similar response saying, “I would classify my current work as more efficient with a less efficient process due to the EMR steps.”

Participant # 7 said, “I am only more efficient because it’s a computer and not paper charting.”

Themes emerged for medical reimbursement that addresses RQ5 are included in Table 5 below:

Table 5.

Themes Regarding Medical Reimbursement (RQ5)

Medical Reimbursement Themes-Category 5 (C5)	Respondents
Reimbursement should not be based on outcomes	*N*= 8
Cannot control patient behavior	*N*=6

The Medical Reimbursement category, C5, provides participants' perspective on reimbursement for care and if patient outcomes should be the indicator. The primary theme emerged from the category was PCPs' perspective that payment should not be based on patient outcomes. Eight out of 9 participants responded that reimbursement should not be tied to patients' medical status.

Participant # 2 said, "reimbursement and outcomes should not be aligned together."

Participant # 4 reported, "basing payment on patient outcomes is not the way to go."

In addition, participants # 3, 5, and 7 all provided similar responses that reimbursement should not be based on patients' health status.

The second theme emerged from C5 was PCPs' perspective that physicians cannot control patient behavior. Six out of 9 participants reported that patient behavior cannot be controlled, thus reimbursement should not be based on outcomes.

Participant # 3 said, “reimbursement for care should not be based on outcomes because I cannot control patients’ behavior at home.”

Participant # 4 reported, “I can provide a care plan, but patients don’t always follow it so I should not be graded based on patient outcomes.”

Participant # 6 also said, “It’s unfair and not realistic that payment be based on outcomes because not all patients will follow their treatment plans.”

Participant # 7 said, “accountability is needed but patients’ medical statuses and how they care for themselves are different, so reimbursement should not be based on outcomes.”

Themes emerged for physician contracts that addresses RQ6 are included in Table 6 below:

Table 6.

Themes Regarding Physician Contracts (RQ6)

Physician Contracts Themes-Category 6 (C6)	Respondents
Metrics should not be in physician contracts	*N*= 9
No evidence of providers’ clinical work	*N*=6

The Physician Contracts category, C6 provides PCPs’ perspective on provider contracts and the appropriateness of embedded quality metrics. The primary theme

emerged from the category was the perspective that quality metrics should not be included in employed physician contracts. Nine out of 9 participants all reported the implementation of quality metrics in physician contracts is not recommended in their perspectives.

Participants # 1-9 all responded with similar perspectives of concern with quality metrics written in physician contracts.

Participant # 2 said, "we cannot add additional pressure on providers with specific quality metrics because there are too many variables that PCP's cannot control."

All participant responses were relatively consistent reporting quality metrics to not be directly written in physician contracts.

The second theme emerged from C6 was PCPs' perspective that quality metrics are not evidence of providers' clinical work. Six out of 9 participants reported quality metrics do not demonstrate clinical work performed during the visit, and holding providers accountable to metrics inserted in contracts are not appropriate.

Participant # 1 reported, "holding me accountable to metrics written in my contracts is not reasonable because patient outcomes do not represent my clinical work plans."

Participant # 3 provided a similar response saying, "quality metrics in a contract do not accurately represent my clinical decisions because I cannot control what patients ultimately decide to do."

Participant # 4 also reported, “my contract doesn’t represent different metrics for different patient populations so it is inappropriate to include metrics that ultimately requires various clinical approaches.”

Themes emerged for quality improvements that addresses RQ7 are included in Table 7 below:

Table 7.

Themes Regarding Quality Improvements (RQ7)

Quality Improvements Themes-Category 7 (C7)	Respondents
No improvements in patient quality	*N*= 6

The Quality Improvements category, C7 reported PCPs’ perspective on improvements in patient care as a result of quality initiatives. The primary theme emerged from the category was PCPs did not see direct improvements in patient outcomes with the implementation of quality focused payment models. Six out of 9 participants reported quality metrics does not alter patient outcomes.

Participant # 2 said, “the EMR has improved through checks and balances of quality initiatives but does that improve my patient outcomes, no.”

Participant # 5 responded, “I think that having metric targets is okay from a process standpoint, but to say care improves is not accurate as there are so many other factors that contributes to improving patient outcomes.”

Participant # 6 said, “in some cases quality may improve, like reminding a patient to take a test but I would have did that anyway, and didn’t need to take all these additional steps in my visit to meet a particular measure. That is not necessarily improving quality outcomes.”

All participants responded appropriately to study questions. No concerns were identified that qualify as a discrepant case. Data analysis included all interview responses. Data was recorded and documented accurately to align with specific participant interview responses. The analysis was careful to avoid inclusion of any unclear or inaccurate data. Data analysis involved review of field notes and tape recordings to ensure quality of the data analysis and results.

Evidence of Trustworthiness

To ensure credibility, transferability, dependability, and conformability of the study, the research design and methods were consistent with the description outlined in Chapter 3. Credibility was exemplified as member checks were conducted to ensure accuracy of collected data. Participant responses were clear and required no additional follow up interviews for clarification of data collection. Participants’ knowledge on quality focused initiatives that impact payment was strong and led to ample development

of themes, which alleviated the need for an additional subject matter expert to review the data.

Transferability was employed as participant variation included equal representation from each PCP specialty to include: internists, pediatricians, and family practitioners. Participant interviews were conducted at seven different practice locations in order to increase variation in data collection. To establish dependability, data audit trials included close evaluation of hand written data recorded during interviews to ensure consistency with data transcribed from audiotapes. Each participant was provided the opportunity to validate interview responses to ensure appropriate representations which demonstrated the use of conformability. All codes were double checked to confirm accurate and appropriate alignment to themes and categories.

Summary

Chapter 4 presented a brief review of the study purpose and research questions. The setting and participant demographics were described in detail. Data collection was presented to include specifics on each data collection instrument, variations, and unusual circumstances encountered. Evidence of trustworthiness was outlined to demonstrate the reliability and validity of the data. This chapter also reported on the data analysis and results. Seven primary themes that emerged from the data analysis were presented to include:

1. PCPs reported that the expectation is not clear from the organization on how to achieve quality metrics (RQ1).

2. PCPs believed development of quality metrics should not be based on patient outcomes (RQ2).
3. PCPs' perspective is that additional quality metric responsibilities will decrease individual physician compensation (RQ3).
4. PCPs believed the implementation of quality metrics will result in less efficiency and a decline in the number of patients they are able to see (RQ4).
5. PCPs reported medical reimbursement should not be based on patient outcomes (RQ5).
6. PCPs' perspective is that quality metrics should not be written in physician contracts (RQ6).
7. PCPs reported that the implementation of quality focused payment models does not improve patient outcomes (RQ7).

Interview responses analyzed from the data collection were presented and are included in appendix E.

Chapter 5 will present (1) interpretation of the findings; (2) limitations of the study; (3) recommendations; and (4) implications for positive social change.

Chapter 5: Summary, Conclusions, and Recommendations

The purpose of this qualitative phenomenological study was to understand through interviewing 9 PCPs, their perspectives on the transition from volume to quality focused payment models. The study was conducted to determine if the quality of care provided improves as a result of health care reform and the shift to align payment with patient outcomes. The findings of the 9 interviews were analyzed based on seven categories, which closely aligned to the research questions. The categories included (a) quality metrics, (b) quality metric concerns, (c) provider compensation, (d) efficiency, (e) medical reimbursement, (f) physician contracts, and (g) quality improvements. The interview responses led to sets of emerging themes under each of the seven categories. Seven primary and 8 secondary themes emerged from the data collection. The interview protocol was specifically designed to be consistent with interview questioning to ensure data collection was fair and aligned with research questions.

Interpretation of the Findings

The findings from the study confirmed evidence presented in the literature review related to providers' responsibility to new quality metrics linked to payment. Transitions in medical care are underway as the culture of medicine has shifted towards increased focus on quality initiatives. Goodson (2010) reported the PPACA will reestablish primary care medicine as the basis for medical care. This study sample understood new proposed levels of responsibility in terms of being held accountable for the quality of care provided. The study also disconfirmed the literature review of new quality focused

payment models designed to subsequently improve patient outcomes. Silversmith (2011) reported the goal of payment reform is to alter medical reimbursement with emphasis to improve quality. The findings of this suggest quality is not improved with changes to payment models that focus on quality metrics. Themes emerged from participant responses are interpreted to determine PCPs' overall perspectives on improvements and concerns with new quality focused initiatives.

RQ1: What quality metrics are primary care practices of health care organizations implementing to improve patient visits?

RQ1 addressed the overall level of PCPs' understanding on the specifics of implemented quality metrics and providers' role. The primary theme suggests the expectation from the organization was not clear to PCPs on how to achieve quality metrics. Participant responses indicated misunderstandings on how to specifically meet some of the quality metric expectations. Findings also revealed providers' concern with the EMR as it relates to the many required clicks and misunderstandings of EMR navigation to meet metrics. Verdon (2012) argued it is important for PCPs to understand their role in health care reform not only in point of service care, but also in management of quality and options for problem resolution. The sample did not clearly understand PCPs' quality responsibilities which demonstrate a void for physicians to take the lead role in quality metrics design and problem solving. Calman et al. (2012) also reported as the PPACA provisions require coordinated, comprehensive patient care with specific

focus on disease prevention, it is important for PCPs to take the lead in health care reform.

RQ2: What are the concerns from physicians with having to meet the quality provisions of the PPACA?

RQ2 addressed the concerns of PCPs with having to be accountable for quality metrics. The primary theme was PCPs' concern that development of quality metrics should not be based on patient outcomes. Participants highlighted concerns with being held accountable for outcomes that cannot be controlled directly by the physician. Concerns were raised with patients' noncompliance to care plans and inability to afford required medications, thus impacting patients' health outcomes. Primary care providers suggested quality metrics should be based on the work performed in the exam room and not the actual patient outcome. This notion is contrary to literature reported by Davis et al. (2010) that to promote quality and efficiency, health care opinion leaders supports provider payment models focused on remuneration for value and not volume. Based on participant responses, PCPs are not in favor of this approach due to uncontrollable patient circumstances. This pay-for-performance concept of connecting remuneration to achieved quality indicators is a primary tool to support health reform as reported by Van et al. (2010), and subsequently is found to be a challenge for PCPs to perceive as an improvement to quality.

RQ3: Are physicians concerned that focusing payment on quality will decrease compensation due to potentially limiting the number of patient appointments?

RQ3 addressed the concept of quality payment models and the impact on individual provider productivity and compensation. The primary theme was PCPs are concerned that quality initiatives will decrease providers' individual compensation. All 12 participants reported concern with a decline in compensation. Primary care providers reported adding additional responsibilities through quality initiatives have limited the number of patients that can be seen which consequently decreases compensation. Participants conveyed provider remuneration is based on the number of patients seen in a clinic day and volume is essential to individual compensation. Blumenthal and Tavenner (2010) reported that the PPACA provides nearly 40 billion in financial incentives for achievement of advances in health care processes and outcomes. Payments go to the organizations of employed physicians and not to providers directly. Participant responses extend the literature with concerns of providers' decreased compensation as a result of additional quality initiative responsibilities. The concerns highlight providers' perspective that compensation decreases due to less patients being seen. Current provisions under the PPACA direct all quality improvement financial incentives to the organization which is suggested from the data collection to be of concern to PCPs.

RQ4: How will quality metrics impact providers' ability to see more patients in less time?

RQ4 addressed the implications of additional quality metric responsibilities on providers' ability to be efficient and see more patients. The primary theme was PCPs' perspective that additional quality metric responsibilities will result in less patients being seen. Participants referenced concern with the overall concept of adding more steps to

care provided through quality initiative requirements. Participants suggested additional work to be performed results in less patients being seen due to a decrease in efficiency and the ability meet quality metric expectations in limited time. McDonald and Roland (2009) argued EMR quality documentation requirements has resulted in physician discontent as additional work to be performed threatens the physician-patient relationship. The notion of additional EMR documentation requirements resulting in provider discontent confirms the data collected. Participants reported concerns with extra steps by way of quality initiatives and the consequence it yields with a decrease in overall efficiency in providing care to patients. Data suggest patients are not happy when their physicians are not available, which further decreases the physician-patient relationship.

RQ5: Are physicians in agreement that reimbursements should be based on meeting quality metrics?

RQ5 addressed new payment model provisions of reimbursement for medical care based on pre-determined quality metrics and if providers concur with the new approach. The primary theme was PCPs' perspective that payment for medical care should not be a result of quality outcomes. Participant responses were consistent in that there should be a separation of payment and patient outcomes. The majority of interview responses centered on the argument that basing payment on outcomes is not a favorable approach in providers' perspective. Silversmith (2011) provided in the literature that altering the way physicians are paid is the goal of health reform with increased emphasis on quality improvements at lower cost. The data collection suggests quality and payment should not

be aligned which highlights providers' discontent with the provision. Data suggest that providers are not in favor of reimbursement based on patient outcomes, which further highlights potential challenges with quality metric implementation and physician compliance.

RQ6: Should quality measures play a role in employed physician contracts?

RQ6 addressed the implication of quality metrics being directly written in employed physician contracts. The primary theme was PCPs' perspective that inclusion of quality metrics written in physician contracts is not a favorable approach to take. Nine out of 9 participants all responded with a consistent perspective that quality metrics should be excluded from employed physician contracts. Concern was raised that added pressure on PCPs to meet quality measures coupled with uncontrollable variables are sufficient evidence to not hold providers contractually accountable for meeting identified quality metrics. Bitton et al. (2012) reported providers and nursing staffs are faced with challenges due to increased workloads in order to meet quality expectations aligned with new payment models. The notion that PCPs are under increased pressure to meet quality expectation is consistent with the reported literature. Primary care providers' perspective is that due to the many challenges ahead with new quality focused payment models, physician contracts should not include measures of quality.

RQ7: Are physicians experiencing improvements in the quality of care being delivered as a result of quality initiatives?

RQ7 addressed outcomes of implemented quality metrics and whether or not care subsequently improves as a result of increased focused on quality. The primary theme was PCPs' perspective that direct improvements in patient outcomes as a result of quality focused payment models has not been witnessed. Participants reported EMR processes may improve but does not yield improved patient outcomes. The data collection suggest providers acknowledge improvements in EMR processes, but are concern with the many steps it takes to meet quality metrics that do not ultimately improve patients' medical conditions. Baron (2012) reported the anticipation is payment models focused on quality outcomes instead of volume results in providing the quality of care patients expect to receive. The data collection is not consistent with the reported literature that patients will receive higher quality of care as a result of payment models focused on quality outcomes. Participants reported no direct correlation to improved patient outcomes as a result of quality initiatives. The notion of improved quality through new payment models with quality accountability was not confirmed in the data collection.

Conceptual Framework Support

The study was guided with a conceptual framework grounded in the knowledge of health care access and chronic care models targeted to improve quality outcomes. Access models grounded in the study was (a) Penchansky's model, (b) the Institute of Medicine (IOM) model of access monitoring, and (c) the behavioral model of health services use (Karikari-Martin, 2010). The chronic care model (CCM) was used to guide principles of quality improvement through management of chronic disease. The models supported the

foundation of the study as it relates to participants' perspectives on health care reform and the transition to quality focused payment models.

Penchansky's model measures access through (a) availability, (b) accessibility, (c) accommodation, (d) affordability, and (e) acceptability (Karikari-Martin, 2010). Participant responses addressed components of the access model. Participants reported concern with patient access as a result of new quality expectations and the implications additional work has placed on their medical practice. It was reported that PCPs will see less patients due to decreased appointments as a result of increased pressure to meet measures with limited visit time. PCPs' response to the importance of patient access highlighted the relevance of the five components to Penchancky's model.

The Institute of Medicine (IOM) model of access monitoring was developed to specifically provide a structure of timely care to achievement of optimal outcomes (Institute of Medicine, 1993). The model provides aspects of access related to barriers to care and use of services (Karikari-Martin, 2010). The data collection of the study suggests PCPs understand the importance of the need to provide timely care and alleviate unnecessary barriers to care. Participants spoke to the need to improve the EMR documentation process as new quality initiatives have negatively impacted the process at which patients are cared for. Concern was highlighted in regards to additional time each patient visit takes with meeting new EMR quality metrics. The data did not suggest access was improved and reported barriers to patient care as a result of additional steps to meet quality metrics.

The behavioral model was originally developed to inform policy makers on the motive for why families use health services (Andersen, 1995). The model provides a framework to understand how access to care is influenced by community-level and individual-level characteristics (Davidson et al., 2004). The study findings reported that PCPs are concerned about patient access as it relates to lower social-economic patients. Participants reported some patient populations do not have access to medications, transportation, and options for healthier eating habits. Primary care providers' perspective is that access is limited in lower wage earning communities which impacts individual characteristics. These findings support the behavioral model and the concept of access improvement and the effect of the community and individual level influences.

The CCM was developed as a foundation to redesign practice workflows of primary care and align with the patient-centered medical home (PCMH) model (Suter et al., 2011). The CCM provides a framework for primary care practices to restructure care delivery with specific focus on chronic care management and commitment to provide comprehensive quality care to all patients (Molina-Ortiz et al., 2012). Participants reported increased attention through quality metrics has altered practice workflows into an unfavorable direction. Chronic disease management was acknowledged by PCPs to be a focused area to improve patient outcomes, but comes with challenges as a result of the many additional steps in care management to meet chronic disease quality metrics. The data collection suggests PCPs' practice workflows continue to be altered to align with new chronic disease quality metrics which is consistent with the CCM concept. Primary care providers' response that there is little evidence to support the notion that a redesign

in practice workflows improves outcomes is not consistent with the concept that the CCM framework improves quality.

Limitations of the Study

The study sample included PCPs boarded in internal medicine, family medicine, and pediatrics. The study was limited by providers with restricted understanding of the PPACA's definitions of quality. The internists and family practitioners were more familiar with quality focused payment models than the pediatricians. Although some physicians were more familiar with quality expectations than others, little understanding of the government's provisions for quality was present. A lack of full understanding of the PPACA limited the scope of the study as perspectives on quality initiatives were primarily based on lived experiences with little comparison to government or commercial payers' definition of quality expectations. The study was also limited by individual perceptions of how quality initiatives impacts personal considerations as it relates to compensation and increased workloads. Subjectivity limits the ability to obtain impartial and accurate data due to participants potentially incorporating interview responses that may have personal influences. Efforts to alleviate politically motivated responses included focusing interview questions on objective data collection geared towards lived experiences of quality initiatives and outcomes. The limitation of politically motivated responses potentially still existed as participants acknowledged dissatisfaction in the government's direction of accountability for quality.

Recommendations

The study results reported many themes that highlight PCPs' transition to new quality focused payment models. The literature review provided a foundation to support many of the identified themes in terms of expectations of new quality provisions under the PPACA. The literature review did not, however, address many of the identified themes presented in the study as it relates to PCPs perspectives on results of new quality initiatives. Participants' responses validated the direction and new focus the government has placed on PCPs' accountability to quality and patient outcomes. Additional research is needed to further evaluate the themes and categories identified in this study. Opportunity for future study will assist in the identification of solutions to close the gap in the inefficiencies and implementation challenges of PCP quality metrics.

Recommendation for future research would be PCPs intellectual understanding of the PPACA and specific knowledge of expectations. It is important for providers to understand the future of health care in terms of what they perceive is the expectation of quality. The exploration should also study PCPs' philosophy on quality improvements from a lessons learned approach. The PPACA has mandated quality improvement provisions for providers and organizations and future study on outcomes coupled with policy amendment recommendations would be beneficial to the literature. The field will also benefit from study on financial incentives organizations have explored to assist in PCPs meeting quality measures.

Another recommendation for future exploration is identification of workflow inefficiencies as a result of quality metric implementation. New approaches to improve EMR documentation processes are recommended to improve workflows. This study reported concerns from PCPs with the EMR documentation processes as a result of attempts to meet quality expectations. Future research on EMR processes and documentation will benefit the literature as PCPs reported the EMR to be a primary component which influenced providers' ability to improve quality. Further study will assist in identification of strategies to streamline the documentation processes in order to save providers valuable time. As time is saved with EMR documentation, providers will have increased opportunity to spend more time with patients as was reported to be of concern in the data collection.

Implications for Positive Social Change

The results of this study highlight social change opportunities at the individual, organizational, and policy levels. The data reported that PCPs are not in favor of new quality focused payment models as changes have negatively impacted physicians' medical practices. At the individual level, PCPs will benefit from the study as providers will be better informed on what to expect as quality initiatives are implemented. An understanding of expectation improves preparedness. The organizational level will benefit as the study provides health care systems PCPs' perspectives on the successes and areas of improvement for quality implementation. It is important for organizations to understand how the workflows of providers are impacted in order to improve processes. PCPs reported concerns related to new challenges to seeing patients due to increased

workloads and complicated measures of quality expectations. Organizations will have the opportunity to adjust quality initiative implementation strategies as a result of the study. The study will also benefit policy development as it relates to health care quality improvements. The implementation of the PPACA has resulted in many contentious debates over its effectiveness. This study will benefit policy development as health care reform is evaluated. Policy makers will have the opportunity to evaluate the data from this study as it relates to the effectiveness and implementation challenges of health care reform.

The study was grounded in access and chronic disease management conceptual frameworks. The conceptual framework provides a foundation of health care quality as it relates to workflow redesigns in order to improve patient access to care and improvement of chronic diseases. Access and chronic disease management are both provisions under the PPACA to improve overall patient outcomes and reduce costs. This study benefits models of care to improve access and chronic disease outcomes as the data collection provides specific criteria identified by PCPs on best practices to meet goals of access and chronic disease concepts.

This study will directly benefit the clinical practices of PCPs. It is recommended that health care organizations and legislators re-evaluation the implementation of quality focused payment model strategies to improve current medical practices. Providers will reap benefits as organizations alter implementation strategies of quality initiatives to align with PCPs' perspectives on identified challenges. Areas of improvement in EMR

documentation processes and thresholds of quality metrics are components that PCPs will directly benefit from. The processes of quality implementation were reported in the study as a major barrier to providers effectively seeing patients in a timely manner. As the study captures the attention of organizations to improve process, PCPs' medical practices will see profound enhancements as efficiency when seeing patients improves.

Policy makers will also play an instrumental role in the improvement of clinical practice as laws impacting physicians' expectation to quality accountability are appropriately evaluated to align with effectiveness concerns identified by PCPs. The PPACA was implemented without adequate attention to the law as acknowledged by many stakeholders of health reform. A re-evaluation of the law as a result of data presented in this study will improve efficiency concerns emphasized by PCP responses.

Conclusion

The purpose of this study was to analyze providers' transition to new quality focused payment models and determine through PCPs' perspective if quality is improved. The PPACA has altered the way providers practice medicine through implementation of quality focus initiatives which holds providers accountable for outcomes. Health care organizations have increased the awareness of patient outcomes under new quality provisions of the PPACA. Primary care providers are under increased pressure to improve care provided to patients as measures of quality are the new source of payment for care. The perspective of providers is that implementation of quality metrics has minimal effective on patient outcomes. Primary care providers' medical practices have

undergone many changes as a result of new quality initiatives which have resulted in provider discontent due to increased workloads and less efficiency. Organizations and policy makers are instrumental to improve the current challenges identified by PCPs as each entity should re-evaluate processes and provider expectations to align with implementation concerns identified in this study.

References

Abrams, M., Nuzum, R., Mika, S., & Lawlor, G. (2011). How the Affordable Care Act will strengthen primary care and benefit patients, providers, and payers. *Issue Brief (Commonwealth Fund)*, *1*1-28.

Accountable Care Organizations. American health care needs to be cured of its high-spending, disorganized ways. Are accountable care organizations the right medicine?. (2011). *Harvard Health Letter / From Harvard Medical School*, *36*(6), 6-7.

Adashi, E., Geiger, H., & Fine, M. (2010). Health care reform and primary care--the growing importance of the community health center. *The New England Journal of Medicine*, *362*(22), 2047-2050. doi:10.1056/NEJMp1003729

American College of Physicians. (2009). Solutions to the Challenges Facing Primary Care Medicine. [Policy monograph.] Philadelphia, PA: American College of Physicians.

Ancker, J., Barrón, Y., Rockoff, M., Hauser, D., Pichardo, M., Szerencsy, A., & Calman, N. (2011). Use of an electronic patient portal among disadvantaged populations. *Journal of General Internal Medicine*, *26*(10), 1117-1123. doi:10.1007/s11606-011-1749-y

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*, 1-10.

Baron, R. (2012). New pathways for primary care: an update on primary care programs from the innovation center at CMS. *Annals of Family Medicine*, *10*(2), 152-155. doi:10.1370/afm.1366

Bendix, J. (2013). Private payers re-examining reimbursement. A host of new payment models will bring pressure on PCPs to hold down costs, improve quality. *Medical Economics*, *90*(4), 48.

Berwick, D. (2013). Don Berwick, MD on transitioning to value-based health care. *Healthcare Financial Management: Journal Of The Healthcare Financial Management Association*, *67*(5), 56-59.

Bitton, A., Schwartz, G., Stewart, E., Henderson, D., Keohane, C., Bates, D., & Schiff, G. (2012). Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot. *The Milbank Quarterly*, *90*(3), 484-515. doi:10.1111/j.1468-0009.2012.00672.x

Blumenthal, D., & Tavenner, M. (2010). The "meaningful use" regulation for electronic health records. *New England Journal of Medicine*, *363*(6), 501-504.

Boeckxstaens, P., Smedt, D., Maeseneer, J., Annemans, L., & Willems, S. (2011). The equity dimension in evaluations of the quality and outcomes framework: a

systematic review. *BMC Health Services Research*, *11*209. doi:10.1186/1472-6963-11-209

Calman, N., Golub, M., & Shuman, S. (2012). Primary care and health reform. *The Mount Sinai Journal Of Medicine, New York*, *79*(5), 527-534. doi:10.1002/msj.21335

Calman, N., Hauser, D., Leanza, F., & Schiller, R. (2012). Family medicine: a specialty for all ages. *The Mount Sinai Journal Of Medicine, New York*, *79*(5), 603-609. doi:10.1002/msj.21333

Calman, N., Hauser, D., Lurio, J., Wu, W., & Pichardo, M. (2012). Strengthening public health and primary care collaboration through electronic health records. *American Journal of Public Health*, *102*(11), e13-e18. doi:10.2105/AJPH.2012.301000

Calman, N., Hauser, D., Weiss, L., Waltermaurer, E., Molina-Ortiz, E., Chantarat, T., & Bozack, A. (2013). Becoming a patient-centered medical home: a 9-year transition for a network of Federally Qualified Health Centers. *Annals of Family Medicine*, *11 Suppl 1*S68-S73. doi:10.1370/afm.1547

Cantor, J., Thompson, F., & Farnham, J. (2013). States' commitment to Medicaid before the Affordable Care Act: trends and implications. *Inquiry: A Journal Of Medical Care Organization, Provision And Financing*, *50*(1), 71-84.

Capretta, J.C. (2010). The independent payment advisory board and health care price controls. Retrieved from http://www.kaiserhealthnews.org/Columns/2010/May/050610Capretta.aspx.

Coalition for Affordable Health Coverage. (2010). Meet America's uninsured. Retrieved from http://www.cahc.net.meet.html

Collins, S. (2012). Primary Care Shortages: Strengthening This Sector Is Urgently Needed, Now and in Preparation for Healthcare Reform. *American Health & Drug Benefits*, *5*(1), 40-47.

Cohn, D., Leitao, M., Levenback, C., Berkowitz, R., Roman, L., Lucci, J., & ... Goff, B. (2013). Reporting of quality measures in gynecologic oncology programs at Prospective Payment System (PPS)-Exempt Cancer Hospitals: an early glimpse into a challenging initiative. *Gynecologic Oncology*, *130*(3), 403-406. doi:10.1016/j.ygyno.2013.05.026

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed). Thousand Oaks CA: Sage Publications.

Darnell, J. S. (2013). Navigators and Assisters: Two Case Management Roles for Social Workers in the Affordable Care Act. *Health & Social Work*, *38*(2), 123-126.

Davidson, P., Andersen, R., Wyn, R., & Brown, R. (2004). A frame- work for evaluating safety-net and other community-level fac- tors on access for low-income populations. *Inquiry*, *41*, 21-38.

Davis, K., Guterman, S., Collins, S. R., Stremikis, K., Rustgi, S., & Nuzum, R. (2010). Starting on the path to a high performance health system: Analysis of the payment and system reform provisions in the Patient Protection and Affordable Care Act of 2010. New York, NY: The Commonwealth Fund.

Delbanco, S. (2011). Interview with a quality leader: Dr. Suzanne Delbanco, on healthcare payment reform. Interviewed by Kevin Warren. *Journal For Healthcare Quality: Official Publication Of The National Association For Healthcare Quality*, *33*(3), 25-27.

DeLia, D., Hoover, D., & Cantor, J. C. (2012). Statistical Uncertainty in the Medicare Shared Savings Program. *Medicare & Medicaid Research Review*, *2*(4), E1-e15. doi:10.5600/mmrr.002.04.a04

DesRoches, C., Audet, A., Painter, M., & Donelan, K. (2013). Meeting meaningful use criteria and managing patient populations: a national survey of practicing physicians. *Annals Of Internal Medicine*, *158*(11), 791-799. doi:10.7326/0003-4819-158-11-201306040-00003

Devers, K., & Berenson, R. (2009). Can accountable care organizations improve the value of health care by solving the cost and quality quandaries?.

Dowd, B., Parashuram, S., Swenson, T., Kane, R., Coulam, R., & Knutson, D. (2013). Value-based purchasing for physician services. *Minnesota Medicine*, *96*(4), 43-45.

Druss, B., & Mauer, B. (2010). Health care reform and care at the behavioral health--primary care interface. *Psychiatric Services*, *61*(11), 1087-1092. doi:10.1176/appi.ps.61.11.1087

Duska, L., & Engelhard, C. (2013). The Patient Protection and Affordable Care Act: what every provider of gynecologic oncology care should know. *Gynecologic Oncology*, *129*(3), 606-612.

Elmendorf, D.W. (2010). Manager's recommendation to reconciliation proposal. congressional budget office. Retrieved from http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliation Proposal.pdf.

Ferman, J. (2010). Healthcare reform: Medicare & Medicaid Innovation Center. CMS provision will test new payment and service delivery models. *Healthcare Executive*, *25*(4), 58.

Filson, C., Hollingsworth, J., Skolarus, T., Clemens, J., & Hollenbeck, B. (2011). Health care reform in 2010: transforming the delivery system to improve quality of care. *World Journal Of Urology*, *29*(1), 85-90. doi:10.1007/s00345-010-0609-4

Fiscella, K. (2011). Health care reform and equity: promise, pitfalls, and prescriptions. *Annals Of Family Medicine*, *9*(1), 78-84. doi:10.1370/afm.1213

Friedberg, M. W., Hussey, P. S., & Schneider, E. C. (2010). Primary care: a critical review of the evidence on quality and costs of health care. *Health Affairs*, *29*(5), 766-772.

Gensichen, J. (2006). Teaching chronic illness care... Wagner, E., Austin, B. & Von Korff, M. (1996) Organizing care for patients with chronic illness, Milbank Quarterly, 74, pp. 511-544. *Medical Teacher*, *28*(1), 93.

Giles, K. (2011). 6 strategies for building bundled payments. *Healthcare Financial Management: Journal Of The Healthcare Financial Management Association*, *65*(11), 104.

Gold, M. (1998). Beyond coverage and supply: Measuring access to healthcare in today's market. Health Services Research, 33, 625-652.

Goodson, J. (2010). Patient Protection and Affordable Care Act: promise and peril for primary care. *Annals Of Internal Medicine*, *152*(11), 742-744. doi:10.1059/0003-4819-152-11-201006010-00249

Haas, S. A. (2013). Debunking Myths Regarding Provisions of the Affordable Care Act. *AAACN Viewpoint*, *35*(2), 6-11.

Halladay, J., Stearns, S., Wroth, T., Spragens, L., Hofstetter, S., Zimmerman, S., & Sloane, P. (2009). Cost to primary care practices of responding to payer requests for quality and performance data. *Annals Of Family Medicine*, *7*(6), 495-503. doi:10.1370/afm.1050

Henry R. Kaiser Family Foundation. (2010). Financing new Medicaid coverage under health reform: the role of the federal government and states. Focus on Health Reform.

Hernandez, A. F., Greiner, M. A., Fonarow, G. C., et al. (2010). *Relationship between early physician follow-up and 30 day readmission among Medicare beneficiaries hospitalized for heart failure.* JAMA; 303:1716-22.

Hertz, B. (2013). How the ACA is reshaping medicine. Improvements in compensation, payer collaboration offset by provider shortages, incentive uncertainty. *Medical Economics*, *90*(4), 30.

Hofer, A., Abraham, J., & Moscovice, I. (2011). Expansion of coverage under the Patient Protection and Affordable Care Act and primary care utilization. *The Milbank Quarterly*, *89*(1), 69-89. doi:10.1111/j.1468-0009.2011.00620.x

Howard, B. (2012, September). 11 myths about health care reform [Electronic version]. *AARP The Magazine, 65*(6C), 66-69. Retrieved from http://www.aarp.org/health/health-insurance/info-09-2012/medicare-and-health-care-reform-myths.html

Inglehart, J. K. (2009). Finding money for health care reform-rooting out waste, fraud, and abuse. *New England Journal of Medicine*, 361:229.

Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, *360*(14), 1418-1428.

Johnson, D. (2011). PQRI, VBP, ACO, eRx, MoC …: understanding the lexicon of health-care-reform legislation. *The American Journal Of Gastroenterology*, *106*(9), 1570-1574. doi:10.1038/ajg.2011.289

Karash, J. (2013). Investing in value-based health care. *Hospitals & Health Networks / AHA*, *87*(5), 54-58.

Karikari-Martin, P. (2010). Use of healthcare access models to inform the patient protection and affordable care act. *Policy, Politics & Nursing Practice*, *11*(4), 286-293.

Larkin, H. (2010). Bundled payments and the board's role. *Trustee: The Journal For Hospital Governing Boards*, *63*(9), 4 pages following 14.

McDonald, R., & Roland, M. (2009). Pay for performance in primary care in England and California: comparison of unintended consequences. *Annals Of Family Medicine*, *7*(2), 121-127. doi:10.1370/afm.946

Mechanic, R., & Altman, S. (2010). Medicare's opportunity to encourage innovation in health care delivery. *The New England Journal Of Medicine*, *362*(9), 772-774. doi:10.1056/NEJMp1001013

Medicare program; Medicare Shared Savings Program: Accountable Care Organizations. Final rule. (2011). *Federal Register*, *76*(212), 67802-67990.

Molina-Ortiz, E., Vega, A., & Calman, N. (2012). Patient registries in primary care: essential element for quality improvement. *The Mount Sinai Journal Of Medicine, New York*, *79*(4), 475-480. doi:10.1002/msj.21328

Orszag, P. R., & Emanuel, E. J. (2010). Health care reform and cost control. *New England Journal of Medicine*, *363*(7), 601-603.

Painter, R., & Painter, M. (2013). PQRS: There's still time to avoid penalties in 2015. *Urology Times*, *41*(10), 34.

Palinkas, L., Horwitz, S., Green, C., Wisdom, J., Duan, N., & Hoagwood, K. (2013). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Administration And Policy In Mental Health*,

Patient Protection and Affordable Care Act. (2010). Pub L No. 111–148.

Peccoralo, L., Callahan, K., Stark, R., & DeCherrie, L. (2012). Primary care training and the evolving healthcare system. *The Mount Sinai Journal Of Medicine, New York*, *79*(4), 451-463. doi:10.1002/msj.21329

Penchansky, R., & Thomas, J. (1981). The concept of access: Defi- nition and relationship to consumer satisfaction. Medical Care, 19, 127-140.

Reid, R., Fishman, P., Yu, O., Ross, T., Tufano, J., Soman, M., & Larson, E. (2009). Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. *The American Journal Of Managed Care*, *15*(9), e71-e87.

Ricketts, T. (2011). New models of health care payment and delivery. *North Carolina Medical Journal*, *72*(3), 197-200.

Riegelman, R. (2011). *Health reform 101: What it means to you and to the American people*. Sudbury, MA: Jones and Bartlett Learning.

Rittenhouse, D. R., Shortell, S. M., & Fisher, E. S. (2009). Primary care and accountable care—two essential elements of delivery-system reform. *New England Journal of Medicine*, *361*(24), 2301-2303.

Rittenhouse, D., Thom, D., & Schmittdiel, J. (2010). Developing a policy-relevant research agenda for the patient-centered medical home: a focus on outcomes. *Journal Of General Internal Medicine*, *25*(6), 593-600. doi:10.1007/s11606-010-1289-x

Robin, D., & Gershwin, R. (2010). RAC attack--Medicare recovery audit contractors: what geriatricians need to know. *Journal Of The American Geriatrics Society*, *58*(8), 1576-1578. doi:10.1111/j.1532-5415.2010.02974.x

Schwartz, M. (2012). Health care reform and the primary care workforce bottleneck. *Journal Of General Internal Medicine*, *27*(4), 469-472. doi:10.1007/s11606-011-1921-4

Scott, A., Sivey, P., Ait Ouakrim, D., Willenberg, L., Naccarella, L., Furler, J., & Young, D. (2011). The effect of financial incentives on the quality of health care provided by primary care physicians. *The Cochrane Database Of Systematic Reviews*, (9), CD008451. doi:10.1002/14651858.CD008451.pub2

Shaffer, E. (2013). The affordable care act: the value of systemic disruption. *American Journal Of Public Health*, *103*(6), 969-972. doi:10.2105/AJPH.2012.301180

Shay, P. D., & Mick, S. S. (2013). Post-Acute Care and Vertical Integration After the Patient Protection and Affordable Care Act. *Journal Of Healthcare Management*, *58*(1), 15-27.

Shomaker, T. (2010). Commentary: health care payment reform and academic medicine: threat or opportunity?. *Academic Medicine: Journal Of The Association Of American Medical Colleges*, *85*(5), 756-758. doi:10.1097/ACM.0b013e3181d0fdfb

Silversmith, J. (2011). Five payment models: the pros, the cons, the potential. *Minnesota Medicine*, *94*(2), 45-48.

Sommers, B., Kronich, R., Finegold, K., Po, R., Schwartz, K., Glied, S., (2012). *Understanding participation rates in Medicaid: Implications for the Affordable Care Act.* Washington, DC: U.S. Department of Health and Human Services.

Spillman, M., & Sgo Government Relations, C. (2011). Until debt do us part. *Gynecologic Oncology*, *123*(3), 455.

Stange, K., Nutting, P., Miller, W., Jaén, C., Crabtree, B., Flocke, S., & Gill, J. (2010). Defining and measuring the patient-centered medical home. *Journal Of General Internal Medicine*, *25*(6), 601-612. doi:10.1007/s11606-010-1291-3

Suter, P., Hennessey, B., Florez, D., & Newton Suter, W. (2011). Review series: Examples of chronic care model: the home-based chronic care model: redesigning home health for high quality care delivery. *Chronic Respiratory Disease*, *8*(1), 43-52. doi:10.1177/1479972310396031

US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology (2010). Health information technology: initial set of standards, implementation specifications, and certification criteria for electronic health record technology, Final Rule. Fed Regist; 75: 44589–44654.

US Department of Health and Human Services (2011). Report to Congress: National Strategy for Quality Improve- ment in Health Care. http://www.healthcare.gov/law/ resources/reports/quality03212011a.html.

US Department of Health and Human Services, Centers for Medicare and Medicaid Services (2012). The Affordable Care Act: Helping Providers Help Patients. http:// www.cms.gov/Medicare/Medicare-Fee-for-Service-Pay ment/ACO/downloads/ACO-Menu-Of-Options.pdf.

Van Herck, P., De Smedt, D., Annemans, L., Remmen, R., Rosenthal, M., & Sermeus, W. (2010). Systematic review: Effects, design choices, and context of pay-for-performance in health care. *BMC Health Services Research*, *10*247. doi:10.1186/1472-6963-10-247

Verdon, D. (2012). Reinventing healthcare. Managing patient populations to become new role for PCPs. *Medical Economics*, *89*(19), 53-55.

Weeks, W., Rauh, S., Wadsworth, E., & Weinstein, J. (2013). The unintended consequences of bundled payments. *Annals Of Internal Medicine*, *158*(1), 62-64. doi:10.7326/0003-4819-158-1-201301010-00012

Zimlich, R. (2013). The PQRS challenge: Will quality metrics improve care or create more reimbursement red tape?. *Medical Economics*, *90*(7), 18.

Zimlich, R. (2013). Rewarding for value. Value-based payment models healthier for patients and economically viable for PCPs, groups report. *Medical Economics*, *90*(10), 31.

Appendix A: Subject Recruitment

Kevin Jackson, Ph.D. Candidate

Health Services-Public Health Policy

Walden University

Phone Script

I am a PhD candidate and currently writing my dissertation. I am conducting a study on health care reform and providers' transition from volume to quality payment models. My study specifically focuses on primary care providers' perspective to determine if care is improved with the implementation of quality payment models.

I would like to invite you to participate in my data collection. Participation will be a face to face interview and take approximately 30-45 minutes of your time. I will conduct the interview at your practice for your convenience. The process is being overseen by Walden University and Bon Secours' Institutional Review Boards. Are you interested in participating in the study?

If yes, thank you for your participation. I will follow up with you with additional details in regards to the date, time, and consent form. Here is my contact information if you have any questions (provide phone number).

If no, thank you for your time and consideration. Here is my contact information if you have any questions (provide phone number).

Appendix B: Cover Letter to Bon Secours Institutional Review Board

Study Title: Health Care Reform and the Transition from Volume to Quality Payment Models: A Primary Care Focus

Kevin Jackson, Ph.D. Candidate

Walden University

Reason for the Study: Dissertation

The study will highlight the anticipated changes in payment models that will connect reimbursements to quality outcomes and seek providers' input. This is important because providers will need to consider the variables associated with payment reform to include the following: (1) implications to patient visits; (2) personal compensation; (3) how quality will be measured; (4) adjusting to EMR quality metrics; (5) defining patient flow and who does what in the office; and (5) how physician to patient relationships will be impacted by seeing more patients in less time while adding additional quality metric responsibilities.

Submission Materials:

1. IRB Initial Study Review Submission Form
2. Interview Protocol
3. Subject Recruitment
4. Informed Consent
5. Principle Investigator CV
6. Training Certification
7. Letter of Cooperation
8. Signed Confidentiality Agreement (In IRB Study Review Submission Form)
9. Signed Statements of Compliance (In IRB Study Review Submission Form)

Appendix C: Informed Consent Information Sheet

You are invited to take part in a research study of Primary Care Physicians (PCPs) to analyze health care reform and the transition to new payment models with specific emphasis on patient outcomes. The study will obtain your perspective on quality focused payment models and determine if care is improved measurably. The researcher is inviting PCPs who are boarded in Family Practice, Internal Medicine, and Pediatrics. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Kevin Jackson, who is a doctoral student at Walden University. You may already know the researcher as an Administrative Director, but this study is separate from that role.

Background Information:
The purpose of this study is to understand PCPs' transition to new payment models which connect reimbursement for medical care to quality outcomes under provisions of the PPACA. PCPs play an instrumental role to improve the quality of care delivered and the specifics of their responsibilities under new provisions of the PPACA will be defined.

Procedures:
If you agree to be in this study, you will be asked to:

Participate in an interview.
Provide 30-45 minutes of your time to focus specifically on the interview.

Here are some sample questions:

What quality metrics are primary care practices of health care organizations implementing to improve patient visits?

Are physicians in agreement that reimbursements should be based on meeting quality metrics?

Should quality measures play a role in employed physician contracts?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Bon Secours Health System will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time. You may also choose to skip any interview questions you do not wish to answer.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming upset on health care reforms initiative to improve patient outcomes by the connection of reimbursement for medical services to meeting quality metrics. Being in this study would not pose risk to your safety or wellbeing.

Participants will benefit from the study by the opportunity to have their individual perspectives on health care reform and the transition to quality payment models recognized. Providers impacted by new quality focused payment models will be able to impact research on the topic which benefits their medical practice and workflows.

Payment:
No reimbursements or gifts will be provided to participants for their participation in this study.

Privacy:
Any information you provide will be kept confidential. You will not be asked any questions that will personally identify you. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by storing on a password protection software system. Data will be kept for a period of at least 5 years, as required by the university. Your interview will also be audiotaped with no identifiable information but only for purposes of verifying the accuracy of the researcher's interview notes. Once verified, the audiotapes will immediately be destroyed.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via kevin.jackson4@waldenu.edu. If you want to talk privately about your rights as a participant, you can call the Walden University representative who can discuss this with you. The phone number is 612-312-1210. You may also contact Bon Secours Richmond Health System IRB director at 804-627-5157 about your rights as a participant.

The researcher will give you a copy of this form to keep.

Voluntary Agreement to Participate:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. I indicate my voluntary agreement to participate by beginning this interview.

_____

_____

_____

Appendix D: Interview Protocol

Background Information on Interviewer

Kevin Jackson, Ph.D. Candidate

Health Services-Public Health Policy

Walden University

Interview

Health Care reform has changed reimbursement for medical services with greater focus on the quality of care delivered. There will be a series of questions related to new quality focused payment models. The study will analyze reimbursements based on quality and patient outcomes and determine through your perspective if patient care is improved through quality focused initiatives.

At any point you may elect to decline to answer a question and/or withdraw from the interview if you become uncomfortable with the questioning. Do you have any objections to this interview being tape recorded for accuracy of the data collection?

Name: Participant Number (e.g., 1, 2 etc.)

What is your job title?

What is your specialty?

What quality metrics are you responsible for to improve patient outcomes?

How has your medical practice changed as a result of increased focus on quality initiatives?

Do you have concerns with having to meet quality metrics?

Do you spend more or less time with your patients as a result of quality metrics?

Do you see improvements in the quality of care being delivered?

If yes, how has it improved? If no, where are the gaps and opportunities to improvement?

Are you concerned that adding additional steps to care by way of quality initiatives will decrease patient appointments and individual compensation?

As more individuals become insured and gain access to care, how does quality initiatives impact your ability to see more patients? Are you more or less efficient?

Do you agree that reimbursement for medical care should be based on quality outcomes?

As an employed provider, should quality metrics be written in employed physician contracts?

There continues to be growing concern regarding PCP shortages. Are you concerned that the quality of care will be directly impacted by provider shortages?

Do you have any concluding comments you would like to add to the interview?

This concludes our interview. I want to thank you for your time and participation in the study.

Appendix E: Quality Metric Responses

Quality Metric Responses-C1
Participant # 2 reported, “I am not sure I understand how to meet some of the quality metrics asked of me.” Similar to that response was participant # 7, who said, “there are so many clicks in the medical record, that I do not know which ones will meet the measure.” Also participant # 3 stated, “I need more education on how quality metrics have been defined and what my role is.” Participant # 7 reported, “the organization needs to do a better job at defining pediatric quality metrics. Participant # 4 also provided a similar response, stating, “I don’t think the government has made it clear to organizations what doctors’ responsibility is to meet pediatric quality.” Continuing to speak to the need for clear pediatric quality metrics, participant # 8 said, “the organization’s focus seems to be more on adult quality metrics, but I care for pediatric patients too.” Participant # 7 said, “I feel I am responsible to improve chronic diseases, like high blood pressure and diabetes.” Participants # 2 and 9 also reported their responsibility to improve outcomes with blood pressure, diabetes, and cholesterol management.
Quality Metric Concern Responses-C2
Participant # 6 said, “I should not be held accountable to patient outcomes, but to the care plan I provide.” Participant # 8 also reported, “I cannot control what my patients do after they leave the office, thus should not be held responsible based on their individual health outcomes.” Similar to participants # 6 and 8, participant # 2 reported, “the current system is not fair because I am being held responsible for patient outcomes that I cannot control.” Participants # 3 and 5 also provided similar responses of concern that quality metrics should not be based on patient outcomes. Participant # 5 reported, “patients that can afford medications will have better outcomes, so I am already at a disadvantage with a lower socio-economic population of patients.” Participant # 7 said, “I care for an older patient population; so, my quality outcomes will reflect sicker patients compared to doctors that have younger and healthier patients.” Participants # 2 and 3 also reported concern with available resources for patient populations that are poor and thus impact patient outcomes. Participants # 2, 4, 5, and 6 reported that more time was spent navigating through the medical record to meet quality metrics than communicating with the patient. Participant # 3 specifically said, “I have a thousand unnecessary things to do with these quality metrics before I ask the patient what’s wrong, and that’s not good relationship building with patients or representative of high quality.”
Provider Compensation Responses-C3
Participant # 5 said, “yes my patient appointments must decrease because I cannot keep up with these new quality metrics, which means my compensation will decrease.”

The other eleven participants all provided similar responses, acknowledging seeing less patients with a decrease in compensation. Participant # 3 said, "I have been required to do more work with all of these quality metrics; yet, my compensation is dropping because I have to see less patients to get the work done." Participant # 4 responded, "I am giving the same care as I have always done and now I have more work and less money due to a decline in my productivity." Participant # 5 also gave a similar response and said, "I cannot get all these quality metrics completed in the patients' room so I am taking work home all the time with no additional compensation."
Efficiency Responses-C4
Participant # 6 reported, "I understand the idea of improving quality, but there is no way I can manage my same patient load and do all these extra quality initiatives." Participant # 8 provided a similar response saying, "my patient visits are decreasing because of the need to do quality metrics." Participant # 1 said, "These metrics are overwhelming which means less patients will get seen." In addition, participant # 4 responded, "I am now less efficient, which means I must see less patients in order to keep up with documentation." Participant # 3 said, "this system has too many steps to call it quality care." Participant # 4 reported, I am definitely more efficient due to alleviating handwriting, but the EMR has too many clicks which slows me down." Participant # 6 also provided a similar response saying, "I would classify my current work as more efficient with a less efficient process due to the EMR steps." Participant # 7 said, "I am only more efficient because it's a computer and not paper charting."
Medical Reimbursement Responses-C5
Participant # 2 said, "reimbursement and outcomes should not be aligned together." Participant # 4 reported, "basing payment on patient outcomes is not the way to go." In addition, participants # 3, 5, and 7 all provided similar responses that reimbursement should not be based on patients' health status. Participant # 3 said, "reimbursement for care should not be based on outcomes because I cannot control patients' behavior at home." Participant # 4 reported, "I can provide a care plan, but patients don't always follow it so I should not be graded based on patient outcomes." Participant # 6 also said, "It's unfair and not realistic that payment be based on outcomes because not all patients will follow their treatment plans." Participant # 7 said, "accountability is needed but patients' medical statuses and how they care for themselves are different, so reimbursement should not be based on outcomes."
Physician Contract Responses-C6
Participants # 1-9 all responded with similar perspectives of concern with quality

metrics written in physician contracts. Participant # 2 said, "we cannot add additional pressure on providers with specific quality metrics because there are too many variables that PCP's cannot control." All participant responses were relatively consistent reporting quality metrics to not be directly written in physician contracts. Participant # 1 reported, "holding me accountable to metrics written in my contracts is not reasonable because patient outcomes do not represent my clinical work plans." Participant # 3 provided a similar response saying, "quality metrics in a contract do not accurately represent my clinical decisions because I cannot control what patients ultimately decide to do." Participant # 4 also reported, "my contract doesn't represent different metrics for different patient populations so it is inappropriate to include metrics that ultimately requires various clinical approaches."
Quality Improvement Responses-C7
Participant # 2 said, "the EMR has improved through checks and balances of quality initiatives but does that improve my patient outcomes, no." Participant # 5 responded, "I think that having metric targets is okay from a process standpoint, but to say care improves is not accurate as there are so many other factors that contributes to improving patient outcomes." Participant # 6 said, "in some cases quality may improve, like reminding a patient to take a test but I would have did that anyway, and didn't need to take all these additional steps in my visit to meet a particular measure. That is not necessarily improving quality outcomes."