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Exploring the Perception of Patients, Providers, and Healthcare Leaders of the 15-20 Minute Primary Care Visit

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Walden University

College of Management and Human Potential

This is to certify that the doctoral dissertation by

Zuhur Hassan Ahmed

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Walden University
2022

Abstract

Exploring the Perception of Patients, Providers, and Healthcare Leaders of the 15-20 Minute Primary Care Visit

by

Zuhur Hassan Ahmed

MPhil, Walden University, 2019

MBA, Walden University, 2016

BA, Concordia University, 2012

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Management

Walden University
February 2023

Abstract

While primary care plays a vital role in health maintenance and disease prevention, patients’ visits with primary care providers (PCP) are only 15-20 minutes on average. This visit length does not leave ample time for holistic care for patients with low socioeconomic backgrounds, who might also have psychosocial issues alongside their chronic conditions. Employing a qualitative multiple case study research design, this study explored participants' perceptions about the 15–20-minute visit duration with PCPs. Guided by the triple aim framework of improving patient healthcare outcomes, patient satisfaction with care, and cost of care per capita, this study answered the research question exploring the common understandings of participants of the 15-20 minute visit with PCP in primary care clinics. One-on-one semistructured virtual interviews were conducted with 15 participants, five patients of lower socioeconomic backgrounds, five healthcare providers, and five healthcare administrative leaders. Using NVivo software, several coding strategies were applied to understand participants' lived experience with the 15-20 minute visit duration with PCPs. Healthcare management practices, patient-physician satisfaction, patient-physician relationship, patient care, and patient visit with PCP were the main themes that emerged from this study. The study results showed that patients, PCPs, and healthcare managers preferred a longer than 15-20 minute patient visit with PCPs. The social change implication of this research is that the findings might have potential benefits for economically disadvantaged populations by aiding healthcare leaders in prioritizing addressing issues with visit duration, access to care, and quality of care for these patient populations.

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Dedication

I want to dedicate this dissertation to my amazing parents, who, even though they did not have the opportunity to attend higher education, worked hard to put my sibling and me through college. I want to dedicate this dissertation to my beloved late father, who installed in me a love for education and knowledge inquiry. Likewise, to my mother, who continuously supports me and pushes me to reach my highest potential even at rough times when I have been ready to give up.

Acknowledgments

First and foremost, I want to express my gratitude to Allah (SWT) for making this journey possible. I want to thank my previous chair Dr. Richard Schuttler, my current chair Dr. Sherly Kristensen, and my second chair, Dr. Jean Gordon, for supporting and guiding me in this journey. I want to thank my family members, particularly my parents, my mother Fosiya Hussein Samatar, and my late father Hassan Ahmed Hussein, for always being extra supportive. I am forever grateful to my wonderful and supportive husband Ahmed Ismail Mahmud (Axamd Deeq), who championed me throughout this process. I want to thank my son, Ismail, for being patient with me and for always finding a way to make me smile. Finally, my wonderful siblings for always being supportive: Ashwaaq, Zamzam, Hodan, Samiya, Abdisalam, Mohamed, and Mustafa.

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Chapter 1: Introduction to the Study

Primary care clinics are the first contact for patients to receive preventative and general health care (Shi & Singh, 2015). Patients seek care from primary care providers (PCPs) for health maintenance, annual checkups, acute care, and continuous care. Prior research on visit durations has suggested that the average patient visit length with a PCP is 15-20 minutes (Migongo et al., 2012; Tai-Seale et al., 2007; Young et al., 2018). To decrease the rising healthcare cost, Medicare changed the method of payments to providers from a fee-for-service to relative value units (RVUs) (Zelman et al., 2014). Private health insurance also determined fixed limits on how much to pay healthcare providers, choosing to pay per number of patients seen, rather than by the services rendered. This system is termed capitation (Zelman et al., 2014). Guidelines put forth by managed care organizations and other healthcare insurance entities has led senior healthcare administrative leaders to responded to these changes in payment reimbursements by increasing the number of patient visits per day (Linzer et al., 2015), thus reducing face-to-face office visit time with PCPs (Zyzanski et al., 1998).

A link has shown to exit between visit duration and quality of care (Chen et al., 2009). Bolen et al. (2016) showed that an extended visit is required to provide holistic care to patients with a diagnosis of diabetes who are also African Americans and were economically disadvantaged. The researchers conducted qualitative research to gain an in-depth understanding of the range and type of health issues presented during primary care visits. The authors purposefully selected an exemplar safety net clinic belonging to a county clinic in Northeast Ohio. The study site was ranked at the top quality of care measure for diabetic patients with low socioeconomic statuses. Bolen et al. explored visit contents and the source of high quality of care scores. The research participants were 15 patients with low socioeconomic status and with a diagnosis of diabetes. Patients were predominantly African American. The average PCP visit length was 28 minutes. During the visit, doctors and patients discussed a range of 25 issues dealing with chronic and acute health and psychosocial issues.

Bolen et al (2016) showed that while PCPs' conversations with the patient focused on chronic disease management, patients initiated discussions addressing psychosocial issues. Bolen et al. found that optimal health can be achieved when patients receive complex care that goes beyond chronic disease management. The authors noted that since the study was conducted at the exemplary healthcare clinic, visit duration had decreased to increase revenue. Regardless of patient complexity, patients were booked for a 20 minutes visit to increase booked appointments and decrease no-show rates. Prior to this change, the visit duration at the clinic was close to 30 minutes. Bolen et al. indicated that primary care visits are complex and long visit duration for patients with low socioeconomic status and chronic conditions is critical to achieving optimal health.

The purpose of this qualitative exploratory multiple case study was to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the 15-20 minute visit with PCPs in primary care clinics. Guided by the triple aim framework of reducing cost, improving patient health outcomes, and patient care satisfaction (Institute of Healthcare Improvement [IHI], 2020), I analyzed the 15-20 minute visit duration with PCPs and the impact of this visit duration on lower socioeconomic status patients. My aim in this chapter was to provide a general overview and a rationale of the study. Chapter 1 consists of the background information, problem statement, study purpose, research question, conceptual framework, nature of the study, and other related sections. In the background of the study section, I reviewed the historical perspective of the 15-20 minute visit policy and reflected on how the general and specific problem of the 15-20 minute visit duration with PCPs are an issue for those of lower socioeconomic status. I expanded on this discussion in Chapter 2.

Background of the Study

In 1992, Medicare implemented changes to the physician payment method to a resource-based relative value scale (RBRVS) system (Getzen, 2015). The decision behind this change was due to rising physician charges and geographical variation (Zelman et al., 2014). As a result, Medicare developed a payment system that reflected the resources needed to care for patients or to perform a procedure (Hariri et al., 2007). The RVUs system was calculated by adding three components together: the work done by the physician, practice, and malpractice expenses (Sodhi et al., 2018). The implementation of RVUs payment system by the Center for Medicare and Medicaid Services (CMS) made an indirect impact on scheduling and patient physician visit length decisions made by senior healthcare leaders.

Since the change in the payment system and visit duration, demands and expectations on physicians have risen without a corresponding increase in visit length (Linzer et al., 2015). Gottschalk and Flocke (2005) assessed physicians' face-to-face patient visit time as well as time used on patient-related work outside of the examination room in a cross-sectional study. Results showed that on a typical workday, doctors spent 55% of their workday outside of the examination room doing documentation and follow-ups for an average of 8.6 hours a day. Of the 8.6 hours, physicians spent an average of 4.72 hours doing face-to-face patient care, 1.25 hours doing patient-related work outside of the exam room, and 1.97 hours doing patient care work outside the exam room when patients were not physically present in the clinic.

Gottschalk and Flocke (2005) compared their findings to the data from the National Ambulatory Medical Care Survey (NAMCS) gathered between 1988 and 1998. The data from the NAMCS showed that primary care face-to-face visit length has increased despite physicians' concern that visit duration has not. Using a 1-sample *t* test, Gottschalk and Flocke noted that they compared the means from their data with NAMCS survey collected in 2003 and found a statistically significant difference between the means at $p < .05$. Data Gottschalk and Flocke did not include the number of patients seen by physicians per day or the average number of minutes physicians spent per patient. However, the authors concluded that the actual time physicians spent on face-to-face patient care have decreased in recent years.

In a more recent study on face-to-face visit time with PCPs, Zallman et al. (2018) examined how including a medical scriber in primary care patient visits would impact physician productivity, face-to-face time spent with patients, and patient comfort. Zallman et al. conducted a prospective observation evaluating productivity, face-to-face time, and patient comfort prior to and post, including medical scribers into the visit at five family, pediatric, and internal medicine safety net health clinics. Using electronic health records (EHR), Zallman et al. evaluated productivity by examining the number of patients seen and the work RVUs. Further, the team evaluated face-to-face time by directly observing the length of time providers spent talking to patients face-to-face and time spent using the computer during the visit. To examine patients' comfort level with medical scribes in the room during the visit, Zallman et al. gave surveys to complete after the visit. The result of the study showed that using medical scribes had an impact on the RVUs per hour.

Zallman et al. (2018) found that using medical scribers freed time for providers to see more patients in a day; thus, the result showed that the number of patients seen in a day increased. The result showed that by using medical scribes to take notes during the visit, providers' face-to-face time with patients increased by 57% at p<.001, and the time they spent on the computer decreased by 27% at p<.001. However, Zallman et al. noted that the study results did not show any significant change to the overall visit time. While Zallman et al.'s findings did not include the visit or face-to-face time length PCPs spent with patients, the research findings suggest the importance of increased face-to-face time with patients.

The standard 15-20 minute visit length is widely used in primary care clinics in the United States of America. Yiu (2004) evaluated the relationships between HMO enrollments and visit length. Yiu concluded that, although the visit length is not directly related to HMO enrollment, the low reimbursement system currently used by HMOs, Medicaid, and Medicare drove physicians to see more patients in a given day, leaving little time for each patient visit.

Despite Yiu (2004)'s conclusion that patient visit duration has decreased since the inception of the new payment system of the 1990s by Medicare, Mechanic et al. (2001) study did not support the claim that changes in payment reimbursement by Managed Care have led to shorter visits with physicians. Mechanic et al. examined the correlation of decreased length of office visits to changes in Managed Care Organizations from 1989 to 1998. The authors analyzed the existing data on office visits from 1989 to 1998 and focused on prepaid visits, such as the ones covered by Managed Care and other insurance. The data were obtained from the National Ambulatory Medical Care Surveys (NAMCS) and the American Medical Association's Socioeconomic Monitoring System (SMS). Mechanic et al. concluded that Managed Care expansions did not cause short visit duration and office visit lengths increased.

Shaw et al. (2014) confirmed Mechanic et al.'s (2001) conclusion that visit duration with primary and specialty providers continued to increase. Shaw et al. analyzed NAMCS survey data from 1993 to 2010 and found that in most specialty and primary care, patient visit length with providers continued to increase. However, Shaw et al. noted that multivariate regression analysis of data from 1997 to 2010 showed shorter visit durations for patients with Medicare or Medicaid insurance. Further, Shaw et al. pointed out possible bias in the NAMCS data. Shaw et al. explained that participating in the NAMCS survey required a large amount of paperwork and assumed that physicians with limited time with their patients might not have the time to participate.

Though visit duration has increased recently, the number of chronic illness patients reported has also increased (Linzer et al., 2015). Further, doctors underbill for topics they address with patients during office visits. Beasley et al. (2004) evaluated whether the number of problems family doctors address during an office visit was reflected in billing and medical charts and found that, on average, 3.05 problems were discussed during each encounter, 2.82 were recorded in the chart, and 1.97 were billed to insurances. Heisler et al. (2003) examined health disparities among patients enrolled in the Medicaid program in a retrospective cohort study. The authors evaluated the difference in health disparities between patients who are seen at clinics owned by educational institutions such as medical universities and those seen in community clinics. Data were obtained from the claims database to estimate cost. Results showed that patients who see their PCPs at academic medical centers (AMC) had a higher cost related to their chronic conditions. Heisler et al. reasoned this to be a result of the managed care reimbursement system that has changed from fee-for-service to the total cost of care per patient per month. The capitation system may create an adverse outcome on the quality of care. Further, Heisler et al. noted that the adverse selection of enrolling Medicaid participants in one plan or provider overwhelms these health plans and providers and puts them at a financial risk.

The managed care organizations capitation payment model does not address the issue of social determinants of health. Ash et al. (2017) examined the effectiveness of a payment model that takes social determinants of health into account. The authors studied 357,660 people enrolled through the fee-for-service payment model and 524,607 managed care organization enrollees. Data were obtained from the Massachusetts Medicaid and Children’s Health Insurance Program, MassHealth. The result showed that a payment model that includes payments for addressing social determinant health performed better than other payment models that did not account for the psychosocial issues of patients.

Researchers in the field of primary care and visit time duration with PCP have examined the effectiveness of the 15-20 minute visit duration with PCPs and concluded that this time frame is not adequate for all patient populations. However, little research has been done focusing on the impact of this visit duration on populations with low socioeconomic status. This research was designed to explore perceptions on the 15-20 minute visit duration with PCP with patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders.

Healthcare payment reimbursement reform requires an extension beyond healthcare facilities (Wang et al., 2009). Populations with low socioeconomic status often experience social factors as determinants of health. Psychosocial issues such as homelessness, lack of adequate and affordable nutrition, and lack of health education increase the risk of chronic illness. Improving the quality of patient care will require changing the healthcare payment system into a system that addresses the psychosocial needs of patients (Wang et al., 2009). Short visits leave little time to do preventative care (Privett & Guerrier, 2021), address health concerns, psychosocial problems are left out of the discussion, and patient education is not included in the visit (Linzer et al., 2015).

Problem Statement

The general management problem addressed in this research is that the standard 15-20 minute patient time scheduled with PCPs is not sufficient to provide holistic and high-quality care in low socioeconomic background patients. Scholars who have conducted studies on the 15-20 minute visit with PCPs determined that psychosocial determinants of health are not addressed by implementation of the 15-20 minute visit duration (Santo et al., 2019). Low socioeconomic status patients face barriers to accessing primary care which disrupts the continuity of care, and they experience short visit duration leading to low patient and physician satisfaction (Becker & Newsom, 2003; Solomon, 2008; Tai-Seale et al., 2007). Arpey et al. (2017) conducted qualitative research exploring how patients with low socioeconomic status perceived their social-economic status's impact on access to care and treatment. Results showed that most of the participants felt that they did not receive adequate care because of their low socioeconomic status. Arepey et al. pointed out that understanding patients' perceptions of care may offer an opportunity to improve care to low socioeconomic populations and enhance the patient-physician relationship. Limited time with primary care decreases preventative rates (Yarnall et al., 2003).

The specific problem is that senior healthcare leaders within low socioeconomic background implementation of the 15-20 minute visit with PCPs as the standard office visit time for primary care patients have created unexpected adverse outcomes in the attempt to achieve the triple aim framework for reducing cost, improving health outcomes, and improving patient satisfaction for patients with low socioeconomic status.

Although the 15-20 minute visit with PCPs might be more than enough time for some patients, others require more time. Little research has been done on the 15-20 minute visit policy and its effect on the overall health of patients from a low socioeconomic background.

Purpose of the Study

The purpose of this qualitative exploratory multiple case study is to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the15-20-minute visit with PCP in primary care clinics. Despite the knowledge around the problem of short visits with the PCPs, researchers' common conclusions are that there is a lack of knowledge about the effect of short visits on different patient populations (Blumenthal et al., 1999). Much of recent studies on patients with low socioeconomic status include the impact of short visit duration with PCPs on patient care (Lichtenstein, 2016). Applying a purposive sampling to identify the interview population, I conducted semistructured interviews using open-ended questions with a total of 15 participants. I interviewed three different stakeholder groups of the 15-20 minute visit durations: five patients from low socioeconomic backgrounds, five primary care providers, and five healthcare administrative leaders of low socioeconomic background. I reported the findings of each group and combined them to demonstrate common findings across the groups. Each grouping was considered an individual case study and then the combined data from all was analyzed for the collective case study findings. I reviewed publicly available secondary sources from government agencies and public libraries as other supporting data assessing patient experience and satisfaction with care to either support or refute potential outcomes of this study to begin to reduce the gap in the literature.

Research Questions

What are the common understandings from patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders about of the 15-20-minute visit with PCP in primary care clinics?

Conceptual Framework

This study was guided by the triple aim conceptual framework developed by the IHI in 2008 to improve healthcare delivery and reduce cost (IHI, 2022). The three aims are to improve patient experience, enhance patient health and quality of care, and to reduce healthcare cost (Obucina et al., 2018). Obucina et al. (2018) evaluated the triple aim framework since its inception and found implementation and applications of this framework varied across health organizations. Obucina et al. reasoned this to be due to the difference between the three dimensions within the framework. The goal of the framework is to enhance quality through a holistic approach model. Part of improving patient experience is to evaluate patients’ experience with delivery of care. Guided by this framework, I gained the common understandings from patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders serving patients with low socioeconomic status about the15-20 minute visit with PCPs in primary care clinics. I then linked the common understandings to the triple aim of quality care, particularly the patient satisfaction aim.

Nature of the Study

Qualitative research entails detailed methodologies that can be directed at different situations for researchers to gain common understandings regarding the inner thoughts of participants about a particular experience or a phenomenon (Guest et al., 2013). A qualitative approach is used in the healthcare field when researchers are interested in obtaining a deeper understanding of patient experience with care (Setia, 2017). For this study, a qualitative research approach was chosen to explore how different stakeholders of the 15-20 minute visits with PCPs have experienced this 15-20 minute visit duration.

An exploratory multiple case study design was chosen for this study. Through case studies, researchers can gain a deeper focus on the case while maintaining a holistic perspective (Yin, 2018). Case study designs are used when exploring bounded findings between units of something unknown to fill a literature gap (Ravitch & Carl, 2016). In this study, I gained an insight into the lived experience of patients, PCPs, and health care administrator leaders with the 15-20 minute visit policy with PCPs.

Definitions

Fee-for-services: A type of payment system for healthcare services provided to patients. Patients, private or government insurance programs reimburse healthcare providers for services patients receive at each encounter (Zelman et al., 2014).

Health maintenance organization (HMO): A healthcare insurance organization that contracts with providers, hospitals, and other healthcare providers. Patients on HMO plans are restricted to receive care, prescriptions, or medical equipment to HMO-contracted healthcare providers (Zelman et al., 2014).

Managed Care: A system of healthcare delivery that includes health insurances and hospital systems. The aim of Managed Care is to lower healthcare cost (Getzen, 2015).

Primary care providers (PCP): Patients receive primary and continuity of care, chronic conditions management, annual physical checkup, and acute illnesses care from PCPs (Shi & Singh, 2015).

Triple aim framework: A quality improvement framework that was established in 2010 to do the following: reduce rising healthcare costs, improve patient health outcomes, and enhance patient experience with care. The triple aim framework was developed by the Institute of Healthcare Improvement (IHI, 2022; Obucina et al., 2018).

Socioeconomic status (SES): A social class of an individual or group that is measured based on occupation, income, and education level.

Assumptions

I assumed that patients and doctors desire to have a more extended visit to address all concerns. Patients often come to address multiple issues, and most doctors are interested in addressing all patients concerns. I assumed that all participants would provide honest responses to the interview questions. To ensure that participants are comfortable to answer questions honestly, biographical data of participants such as name and health-related information were kept strictly confidential. Physicians and healthcare administrator leaders’ information such as name, title, place of work also were also kept confidential.

Scope and Delimitations

Scope

I contacted five different clinics that serve the population of interest so that at least five patients of low socioeconomic status, five providers, and five healthcare administrators would agree to participate in the study. Due to COVID-19 pandemic, clinics didn’t allow me to conduct research and to recruit patients, providers, and healthcare managers at their facilities. I recruited participants, using social media and other avenues. I posted flyers of the study on social media outlets, specifically Facebook and LinkedIn. I also posted recruitment projected on userinterviews.com and Walden Participants Pool. I used Walden Participant Pool to recruit clinic leaders only.

Research participant patients were identified as 18 years old or older low-income patients who had or has a primary care provider, PCPs providing care to low-income patients, or clinic administrators at clinics serving low-income patients. Patients self-identified themselves as low-income patients. Also, data were collected on the type of insurance patients had. Patients who identified themselves as low income were selected. Additionally, during data collection, participants were asked the types of insurance they have. Patients who were in the medical assistance or Medicaid programs were identified as low-income patients. Medicaid and Medicare programs are healthcare insurances paid by the United States government for patients over the age of 65 years and low-income patients (Zelman et al., 2014).

Delimitations

Delimitations are the parameters of the research (Baron, 2008). Contrary to the limitations of studies that are not controlled by the researcher, delimitations are boundaries set by the researcher consisting of inclusion and exclusion criterions (Ellis & Levy, 2009). This study was delimited to patients of low socioeconomic status, providers serving these patients, and healthcare administrator leaders who manage healthcare facilities where these patients receive healthcare. Additionally, this study was limited to adult patients 18 years of age and older. The study excluded providers and healthcare administrator leaders at private healthcare practices.

Limitations

Limitations are occurrences and factors beyond control of the researcher that might impact the internal validity of the research (Ravitch & Carl, 2016). Conducting a research study on human subjects comes with limitations and challenges. When conducting a research study on human subjects, the feasibility of data collection must be taken into consideration (Babbie, 2014). A potential challenge to collecting data from patients is accessing patient health data and contact information. Due to HIPPA privacy, clinics might not allow access to patient records; this might hinder patient participants' selection process. Further, physicians might be limited to discussing specifics about the phenomena of interest due to patient privacy laws and policies. Healthcare leaders might be reluctant to share their decision-making processes, strategies, and best practices. To counterpoise limitations, I did not ask specific health information of patients, such as patients' healthcare problems. Research participants were given informed consent and I shared details of the research with all participants.

Significance of the Study

Significance to Practice

The result of this study might be useful to patients of low socioeconomic status, PCPs, and healthcare administrative leaders serving patients of low socioeconomic background in evaluating the 15-20 minute visit policy with PCPs. In particular, the study helped answer the question: is the 15-20 minute visit with PCPs appropriate for patients of low socioeconomic status? Patients receiving care in inner-city clinics have shorter visit duration than those receiving care in salaried group practices in academic medical centers (AMC) or at managed care group (MCG) clinics (Tai-Seale et al., 2007). The results of the study might help patients gain a perspective on the effects of the 15-20 minute visit duration with PCPs on their care. Further, healthcare providers of low socioeconomic background patients could better understand the common understanding patients and healthcare administrative leaders have on the 15-20 minute visit policy. Lastly, the study could help healthcare administrator leaders at healthcare clinics serving low-income patients to strategize more effective visit policies for populations they serve.

Significance to Theory

Economically disadvantaged patients often experience low access to care (Kirby, 2008). Many researchers in the field of access to care, primary care visit duration, and health quality improvement have focused on patients with chronic conditions and overall access to care. In this research, I specifically explored the 15-20 minute visit with primary care's effectiveness in caring for patients from low socioeconomic backgrounds. The existing literature on the 15-20 minute visit with PCPs has not focused enough on exploring the effectiveness of this visit duration on patients of low socioeconomic status. The research finding from this study might offer insights into an alternative visit policy to the 15-20 minute visit with PCPs for patients from low socioeconomic backgrounds.

Significance to Social Change

The research findings from this study might have potential benefits to economically disadvantaged populations. Lower socioeconomic status is linked to lower health status (Kawachi & Kennedy, 1997). Daepp and Arcaya (2017) examined the effect of health on socioeconomic status, looking at diabetes patients. While the results did not show that higher hemoglobin A1c, a measure of the blood glucose levels in the past three months, did not lead to lower socioeconomic status, the authors found that those with low socioeconomic status had higher hemoglobin A1c. The 15-20-minute visit policy with PCPs hinders the delivery of comprehensive and quality care to patients of low socioeconomic status. According to Linzer et al. (2015), doctors are expected to see as many patients as possible each day to cover the overhead cost; thus, they are limited to a visit length of 15-20 minutes. The results of this study might help healthcare leaders address improving access and quality of care for economically disadvantaged patients.

Summary and Transition

The 15-to 20-minute visit duration might be ideal for many patient populations, particularly those who are only in the office for health maintenance; however, patients with low socioeconomic status issues require additional time with physicians to address psychosocial issues that might be affecting their health. The problem this study addresses is the 15-20 minute visit with PCPs does not leave ample time to address healthcare concerns and psychosocial issues of patients from low socioeconomic backgrounds. A qualitative multiple case study research design was chosen for this study to gain common understandings from patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders about the 15-20 minute visit policy with PCPs in primary care clinics in the United States. Sections outlined in this chapter included the background of the study, the research problem, the purpose of the study, the research question, conceptual framework, and nature of the study, among other related sections. Chapter 2 contains information around the review of the literature that provides for the synthesis and analysis that produces the gap in the literature.

Chapter 2: Literature Review

The purpose of this qualitative exploratory multiple case study was to gain the common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the15-20 minute visit with PCP in primary care clinics. The general management problem to be addressed in this research is that the standard 15-20 minute patient time scheduled with PCPs is not sufficient to provide holistic and high-quality care in low socioeconomic background patients. The specific problem is that senior healthcare leaders within low socioeconomic background implementation of the 15-20-minute visit with PCPs as the standard office visit time for primary care patients has created unexpected adverse outcomes in the attempt to achieve the triple aim framework for reducing cost, improving health outcomes, and improving patient satisfaction for patients with low socioeconomic status.

The triple aim framework (IHI, 2022) will help healthcare leaders strategize and implement healthcare improvement efforts. There are three components to the triple aim framework that focus on lowering healthcare costs per capita (IHI, 2022). Since 2008, healthcare leaders have focused on making drastic changes to the delivery of healthcare to patients across the spectrum. Scholars in the field of healthcare management and healthcare quality improvement have examined, evaluated, and analyzed these different efforts. Rising healthcare costs have been a significant concern that dominates the discourse on healthcare quality improvement.

In reviewing the literature, I evaluated studies regarding visit duration with PCPs and concluded that healthcare disparities and payment reimbursement systems, among others, are barriers to accessing care for patients with low socioeconomic status. Further, I presented the case that these barriers might be due to the lack of a strategic focus from healthcare leaders regarding the issue of short visit duration with PCPs. In doing so, I examined literature on recent efforts made by senior healthcare leaders to fix the healthcare system and the triple aim framework. I presented cases from recent studies examining patients' satisfaction with care and visit duration with providers and concluded that little effort has been made by senior healthcare leaders to improve patient satisfaction. Despite different efforts to improve the delivery of care and reduce costs, little effort has been made to improve visit duration with PCPs.

Literature Search Strategy

I used Source Complete, PubMed, Medline, Academic Search Complete, ABI/Inform Complete, EBSCO, EBSCOHost, CINAHL PLUS with Full Text, CINAHL & MEDLINE Combined Search, Embase, ProQuest, PsycINFO, PubMed, SAGE Journals, SAGE Research Methods Online, Science Direct, Thoreau Multi-Database Search, and Google Scholar. In each database, I used different search terms and keywords. I began my literature search using the key search term *short visits with primary care providers*. Then I narrowed my search to peer-reviewed journal articles. I identified terms in articles I was reading and incorporated these key terms to the search. I used the following key terms: *EHRs and visit length in primary care, psychosocial determinant of health, health disparities and primary care visits, 15-minute visit policy* *with PCPs*, *United States healthcare payment system*, *healthcare quality improvement*, qualitative research, case studies design, *triple aim framework, average visit length, average length of visit*, *primary care and average visit length*, *length of visit and united states, primary healthcare,* and *primary care clinics point of entry USA.* Also, I did a direct search of article titles cited in the bibliographies of articles I was reading. I used Walden University, University of Minnesota, Augsburg College, Chicago Public Library, and Google Scholar databases. Further, I used Google Scholar's Cited by tool to find other relevant scholarly work.

Conceptual Framework

The United States healthcare system is not one unified system. Instead, it is complicated with many different sectors that are controlled by the private industry and government (Shi & Singh, 2015). In the 1960s, United States healthcare was unregulated, and physicians provided care to patients at their homes. Hospitals and healthcare insurance companies did not function in their current form (Mosely, 2008). However, there have always been attempts to enhance how care is delivered to patients. The United States government made several attempts to create a universal healthcare system, but that was opposed by physicians and others who thought healthcare could operate better in the free market (Mosely, 2008). The rising costs of healthcare in the United States challenges senior healthcare leaders to lower costs while improving quality of care.

Senior healthcare leaders' dire need to address rising costs of care have led to the plan and implementation of systemic changes by healthcare leaders that include improving the current care delivery model, so it focuses on enhancing patient experiences with care and improving patient health outcomes. According to Berwick et al. (2008), the triple aim framework of reducing costs per capita, improving patient experiences, and improving population health are interdependent, and all are required to achieve high-value care. Berwick et al. examined the application of the triple aim framework and concluded that the current healthcare system is set up to address the first aim of improving patient experiences with care and not all three. Achieving all three aims might not be a priority to all individual stakeholders.

Since the triple aim framework was instituted, healthcare organizations have made efforts to implement the framework in ways that suited their organizational needs. McCarthy and Klein (2010) conducted a multiple case study involving three organizations participating in the triple aim implementation initiatives of IHI. To present the diverse approaches taken by various healthcare organizations in implementing the triple aim framework, McCarthy and Klein (2010) examined CareOregon, Genesys Health System, and QuadMed healthcare organizations' results from the implementation of the triple aim. McCarthy and Klein found that the three organizations were able to achieve improvements in terms of access to care, patient satisfaction with care, increases in preventative care, chronic disease management, and enhanced behavioral change. These changes led to a reduction in patients' use of healthcare resources such as emergency department use and hospitalization, thus leading to an overall reduction in the cost of care per capita. As noted by McCarthy and Klein (2010), the findings from this study could be beneficial to healthcare organizations interested in replicating the implementations of the triple aim framework used by the three organization in ways that are appropriate to their organization’s culture and needs.

Misconceptions regarding balancing cost reductions and quality of care have kept healthcare organizations from achieving a care delivery model that is high quality and cost-effective. Improving quality does not necessarily mean adding more dollars to the budget; rather, it requires new innovative models of care. Although healthcare leaders’ focus on improving healthcare quality involved enhancing clinical care, since 2010 healthcare organizations and social services agencies have jointly made efforts to integrate healthcare and social services. Clinic leaders created and implemented care coordination services and incorporated healthcare with social services. Coordination services such as helping patients with housing and employment have been developed as a tool to lower healthcare costs and improve patient health outcomes. In doing so, hospital and clinic leaders created care coordination services to address psychosocial needs of low-income patients such as housing, employment, and transportation.

According to IHI (2022), the conceptual framework of the triple aim includes components that help in a systemic change to improve the United States healthcare system. IHI suggests that healthcare organizations include concept designs aimed at population health management, care models that are centered around the patient and family, reduction of cost, integration of social and health services, and to reform primary care clinics. Healthcare organizations’ approaches to implementing the triple aim framework have been diverse and multidimensional. Some of the United States healthcare organizations have focused their efforts on implementing the triple aim framework by focusing on population health management. Other organizations implemented programs such as care coordination services that worked by integrating medical and social services to provide holistic care to patients and to optimize the healthcare system, an essential component of the triple aim concepts.

The triple aim framework addresses three aims of improving the United States healthcare system by improving individual and population health, reducing the per capita cost of care, and enhancing patient experience with care (Whittington et al., 2015). West (2016) suggested to change the triple aim to a quadrable aim framework by adding a fourth aim of improving physician experience with job. Physician satisfaction with job and patient satisfaction with care have been linked to longer visit length. In a study comparing physicians’ perceptions with visit length in three countries, the United States, the United Kingdom, and Germany, United States physicians reported that 30 minutes was allocated for new patient visits and 18 minutes for established patient visits; however, physicians expressed they need more time to provide care to patients (Konrad et al., 2010).

Patient satisfaction with care is an essential aim of the triple aim framework. Few studies have focused on examining a possible association between patient satisfaction with care linked to visit length. Gross et al. (1998) studied 138 family physician practices in Northeast Ohio and examined patient visit length, the content of the visits, and patient satisfaction with outpatient care. The results of the study showed that patients were most satisfied with the long visit length. Scholarly work on patient visit length has shown that the average patient visit with PCP is somewhere between 15 and 20 minutes (Migongo et al., 2012; Tai-Seale et al., 2007). A more recent study evaluated the patient perception of visit length and its relationship to satisfaction with care. Lowe et al. (2019) examined the impact of provider manners and attitudes on patients' perception of the visit length. During a 10-minute encounter with providers, patients' perceptions of the visit length with providers varied. Patients who felt providers were warm, kind, attentive, caring, efficient, and knowledgeable perceived a more extended visit than the fixed 10 minutes.

Research on patient-physician relationships has a new focus that examines physician satisfaction with the job and the impact on patient satisfaction. Bodenheimer and Sinsky (2014) offered a conceptual lens for understanding patient-physician relationships and urged healthcare leaders to expand the triple aim framework by adding a fourth aim that assesses physician satisfaction and implements efforts to improve that. Bodenheimer and Sinsky noted that physician burnout jeopardizes the achievement of the triple aim. Thus, the authors suggested that a fourth aim that focuses on enhancing providers' work life should be added to the triple aim framework.

Despite its usefulness, the scholarly work on healthcare quality improvement does not show efforts done by senior healthcare leaders to address short visits with PCPs and their impact on patients with low socioeconomic statuses. The scholarship on the triple aim framework provides a useful and balanced framework to address cost reduction while improving patient experience with care and health outcomes. Guided by the triple aim framework, particularly the patient satisfaction with care aim, I explored patients', PCPs', and healthcare leaders' common perceptions of the 15-20 minute visit length.

Literature Review

The typical patient visit with a PCP is anywhere from 15-20 minutes (Blumenthal et al., 1999; Shaw et al., 2014 Young et al., 2018). However, research showed that patients spend anywhere from 30 minutes to one hour at the clinic. Primary care clinics are the point of entry to the healthcare system for patients. Patients seek to receive health education, counseling, diagnostic, therapeutic, and prevention services from primary care clinics. Further, primary care clinics are the gatekeepers in that PCPs refer patients to specialty care and in-hospital admission. Therefore, the current visit duration practiced by many primary care clinics is not sufficient to provide holistic and patient-centered care. While the 15- to 20-minute visit duration with PCPs might work for some patients, patients with low socioeconomic status might require a longer visit duration to address psychosocial issues that could impact their health. Results from a study on short visit duration and its impact on patient health outcomes demonstrated that high-volume practices that saw a large number of patients in a day did so at the expense of patients' health outcomes, satisfaction with care, preventative care, and doctor-patient relationship (Zyzanski et al., 1998). A long visit duration greater than 15 minutes is associated with patient satisfaction (Alarcon-Ruiz et al., 2019).

Patient Visit Duration with PCP

The standard 15-20 minute patient visit with PCPs is not enough time to provide holistic and high-quality care for patients with low socioeconomic status. Studies about the length of patient visits with medical providers show that the average visit length is 15-20 minutes (Shaw et al., 2014; Stafford et al., 1999). In this time frame, doctors are expected to do patient care, participate in health administration, and approach patient care in a holistic manner. Patients often come to physicians to address more than one concern. To examine the length of clinical visits, Flocke et al. (2001) conducted a qualitative cross-sectional study to identify the number of chief complaints patients present during a typical visit with a PCP. Flocke et al. approximated that close to three problems per visit were discussed in each visit and observed an increase of 2.5 minutes with every additional problem patient presented. Flocke et al. pointed out that not all concerns discussed during a typical visit were billed, so were not reflective of physician productivity. An increase in visit duration was due to the increase in the number of complaints discussed during the visit.

Patients seek to receive quality, thorough, and holistic care at emergency departments rather than primary care centers. In a cohort study, Lowe et al. (2005) evaluated correlations between emergency department use and primary care practice characteristics in a Medicaid recipient population in Southeastern Pennsylvania from 1998 to 1999. Data were collected on 57,650 Medicaid patients that were assigned to 353 primary care clinics through the Medicaid HMO. Results showed that patients on HMO insurance through Medicaid had a high number of emergency department visits. On the other hand, a low use of the emergency department was seen in patients who belonged to primary care practices with evening and weekend hours.

Further, Lowe et al. (2005) showed that low utilization of the emergency department was seen in patients receiving care from providers who had long visit durations to address patients' concerns. Lowe et al. concluded that access to primary care and characteristics of the practice were correlated to fewer emergency department visits among Medicaid enrollees. Recently O'Malley et al. (2019) examined the correlation between PCPs' comprehensiveness in 2013 and utilization measures such as emergency department use and hospitalization, and Medicare expenditure in 2014. The findings showed that PCPs providing comprehensive care to Medicare beneficiary patients had lower emergency department use rates, hospitalization, and overall service utilization.

Linzer et al. (2000) argued that studies on visit duration have failed to depict the time pressure physicians experience when dealing with large patient panels. A prospective cohort study conducted at a primary care clinic in a large hospital in Massachusset, Lichtenstein (2016) examined primary care visit length, content, and composition. Data was collected from 635 patients and seven PCPs. One visit per patient was analyzed. Patients were identified as physician-defined complex (PDC) patients and non-complex patients. PDC patients who participated in the study were 250 (39.4%). Lichtenstein evaluated the visit length (i.e., the total amount of time in minutes PCPs spent with the patient inside the exam room) and the visit (i.e., activities and topics discussed during the visit). Lichtenstein hypothesized that PDC patients would have longer visit than non-complex patients. The findings from the study conflicted with the authors' prediction.

Litchtenstein (2016) showed that the visit length was the same for PDC and non-complex patients. Meanwhile, the content of the visit was different between the two patient groups. PDC visits were spent mainly on discussing medications, specialty care coordination, and mental health. On the other hand, little time was spent addressing patient education, cancer screening, and psychosocial issues. Lichtenstein highlighted those patients with complex medical issues had an overall high number of visits over time. However, the author argued that despite data from the National Ambulatory Medical Care Survey (NAMCS) showing an increase in primary care visit length in recent years, recent research data findings show that PCPs do not have adequate time to provide holistic and high-quality care for patients. The seven volunteer physician participants in the study had a patient planal ranging from 400 to 1525.

Even though data from Litchtenstein (2016) did not show the average visit duration, complex and non-complex patients had the same visit duration with their PCPs. Lichtenstein concludes that these findings raise questions on the quality of care complex patients are receiving. The author suggested that patients with complex medical conditions require adequate time to address all critical topics for medically complex patients. Even though this study focuses on patients identified by providers as medically complex and non-complex, the study data did not include patients' socioeconomic status. Lichtenstein points out that short PDC patient visit duration with PCPs can lead to drifting away from addressing essential topics that are vital to patient care.

In a thorough systemic review of previous literature on health outcomes and visit length with general practitioners in the United Kingdom and the United States, Wilson and Childs (2002) reported that patients received optimal care with more extended visits. The authors used Medline, EMBASE, and the NHS National Research Registry database. Among the many papers retrieved from this database, 13 papers were selected, and 10 studies were identified within these 13 papers. Upon reviewing the literature, and despite the findings, Wilson and Childs identified a methodological weakness of the studies they examined. The majority of the participants in the studies the authors analyzed involved practices that had smaller patient panels. Wilson and Childs concluded that the results might have excluded practices with larger patient panels and thereby with time pressure. Research work by Lorenzetti et al., (2013), Braddock and Snyder (2005), and Klitzman (2007) have documented the concerns with visit duration and implications on patient satisfaction, patient-physician relationship, and physician job satisfaction.

Scholarly work done by Zyzanski et al. (1998) on clinical outcomes and visit length showed that physicians with high numbers of patients visits during the day also had shorter visit lengths and performed fewer annual physical wellness checks than a regular office visit compared to their counterparts. These physicians were shown to be more efficient than their counterparts. Scholarly work on visit duration with PCPs highlights existence of different contributors to short patient visits with PCPs. Feddock et al. (2005) examined the wait time in the lobby and office visit duration and found that longer waiting time in the physician’s office often led to shorter patient visits with PCPs. Further, the authors evaluated the correlations between patient satisfaction, time spent with physician, and waiting time. Multiple regression analyses showed that 92% of patients reported satisfaction with wait times. The average wait time reported was 12 minutes with a standard deviation of 11 minutes. Patients defined long wait times when they waited in the lobby for more than 15 minutes and in the exam room for more than 10 minutes. Also, patients reported visit length was reasonable when they spent more than 15 minutes with a physician in the exam room and less than 15 minutes in the waiting room. Feddock et al. suggested that the waiting time of 12 minutes is reasonable for patients if the visit duration was extended.

Migongo et al. (2012) identified factors that contribute to lengthening or shortening patients’ visit time with physicians. The authors explored predictors that could lead to visit length by surveying four research questions on factors that increase or decrease visit length, a particular combination of factors that led to the shortest or longest visit, physicians’ role in visit length, and the accuracy of predicted effectors of visit length. The results revealed a combination of predictors that could impact visit length, such as having several diagnoses. Other predictors included tobacco use, chronic conditions, depression or anxiety, age, and post-surgery follow-up. Data from this study also exposed that the average visit was 14.5-minutes. Regression data analysis showed that patients with three or more diagnoses were expected to spend an additional 4.7-minutes with physicians. The result of this study is critical to assessing the actual time physicians spend with patients face to face during the visit.

Barriers to Accessing Healthcare

Health Disparities and the 15-20 Minute Visit Policy

Low socioeconomic status is associated with poor health, high levels of illnesses, and early death (Adler & Snibbe, 2003; Zhang et al., 2019). Existing healthcare disparities put patients with low socioeconomic status at a disadvantage (Blanco et al., 2020). The social determinants of health are environmental factors and conditions in which individuals were born and live that affect the quality of health and life (U.S. Department of Health and Human Services, 2009). Healthcare disparity automatically enables well-off individuals to be healthier than patients with low socioeconomic status, particularly people of color, due to access and cost of care issues (Kirby, 2008). Poor living conditions, unhealthy food, and lifestyle play a significant role in these disparities. Andermann (2016) argued that people with low socioeconomic statuses with less education suffer more from diseases and die earlier than wealthy and educated people. Burgess (2010) claimed that healthcare providers might contribute to healthcare disparities by making treatment and diagnostic decisions that are motivated by the race or social class of patients.

Poverty can cause poor health, and the effects of poverty can begin as early as infancy or even during pregnancy. Children from low socioeconomic backgrounds suffer from poor health. Poulton et al. (2002) examined the impacts of low socioeconomic status on children's health in a cohort study of 1000 children and found that children with economically disadvantaged parents had poorer cardiovascular and dental health and were more prone to substance abuse during adulthood. Chen et al. (2006) assessed health and socioeconomic status changes with age. The authors confirmed that lower socioeconomic status is associated with poor health and further evaluated health status in different age groups. Chen et al. found that while socioeconomic status was associated with global health measures throughout childhood, health measures such as acute illnesses varied between childhood and adolescence. Using data from the 1994 National Health Interview Survey (NHIS) of 33,911 children ages 0 to 18, Chen et al. concluded that socioeconomic status levels are consistent through childhood and adolescent years, but health status changes due to environmental and social factors that are not present during developmental ages.

Looking at life expectancy and the ability to exceed the socioeconomic of parents, Venkataramani et al. (2020) did a cross-sectional ecological study using public data from 1559 counties to evaluate the gap in life expectancy between the rich and the poor and its relation to social mobility. Social mobility is a change in social status that involves moving upward or downward in the social ranking. This research study examined the relationship between social mobility and longevity. The authors used publicly available data at the county level, using the Health Inequality Project database (HIPD) of all 50 United States. Measures that were used included average household income, unemployment rate, income information based on demographics and residential areas, and percentage of individuals without insurance.

Venkataramani et al.'s (2020) main objective was to determine the remaining life expectancy at age 40 years. Using HIPD data, the authors measured social mobility by investigating an individual's parents' income rank against the individual's current income. Results showed an association of greater longevity in counties with high social mobility. Further, in these same counties with high social mobility, results showed a lower gap in life expectancy between the rich and the poor. The study showed that there was a broader gap in longevity between individuals with low socioeconomic status and those with high socioeconomic status. Venkataramani et al. argued that it is due to declining social mobility. More people are staying in the social class in which they were born. If their parents earned a low income, most likely children would stay in that low-income bracket. The findings from this study inform healthcare leaders about social policies that could help eliminate health disparities to improve patient health outcomes.

Several researchers evaluated the impact of the evolving healthcare system on socially disadvantaged populations. Sommers et al. (2016) examined the impact of Medicaid expansion on access to care, healthcare services utilization, and self-reported health among low-income adults. Sommers et al. focused their analysis on three southern states that took different approaches to ACA expansion: Arkansas, Kentucky, and Texas. Arkansas purchased private health insurance from the ACA private market using designated federal funding for ACA expansion for low-income adult patients. Kentucky, on the other hand, utilized the Medicaid ACA expansion to insured low-income patients. Finally, Taxes did not participate in the ACA expansion. According to Sommers et al., southern states are among the states with the highest poverty and uninsured rates in the country. Thus, it is ideal for examining the impacts of Medicaid expansion in these states on patients with low socioeconomic status.

Sommers et al, (2016) surveyed close to 1000 adult patients with low socioeconomic status. The authors compared states that did the expansion (Arkansas and Kentucky) to Texas that did not do the expansion and evaluated the difference in healthcare utilization and self-reported primary care access before and after the expansion. Further comparison was done between healthcare utilization and self-reported primary care access before and after expansion between Arkansas and Kentucky. Results showed an increase in outpatient services, preventative care utilization, and quality of care improvement, and reduction in emergency department visits among low-income patients residing in Arkansas and Kentucky. The results from this study provide justification of the premises of Medicaid expansion and the need to address income-based health disparities.

A more recent study conducted by Kino and Kawachi (2018) focused on the impact of ACA Medicaid expansion on income-based inequalities in the utilization of healthcare services. Kino and Kawachi used Behavioral Risk Factor Surveillance System (BRFSS) data covering 50 United States and the District of Columbia between the years of 2011 and 2016. Kino and Kawachi stated that while the ACA Medicaid expansion improved patients' ability to afford care and hence improved access to care in that manner, the expansion did not address the existing disparities in accessing healthcare services, such as dental, and preventative screenings, such as cancer screening. Access to care is an issue for low-income adults. However, Kino and Kawachi's study offers an opportunity to do further evaluation of the United States' healthcare system and create innovative solutions that address all of the needs of socially disadvantaged populations that go beyond accessing healthcare.

Due to a lack of access to primary care, the authors of one study found that patients with low socioeconomic statuses prefer to use emergency departments for ambulatory care. Kangovi et al. (2013) surveyed why patients with low socioeconomic statuses prefer to receive ambulatory care in an inpatient fashion. Patients expressed that they had better access to care in an inpatient hospital than ambulatory care. Further, patients felt they had a better quality of care at the hospital setting, with some stating that their PCPs did not provide proper care to them. Kangovia et al. identified two types of participant patients. Profile A patients reflected those who had more acute care visits in the previous six months. These patients did not have family support and suffered from disabilities. Patients in profile B did not have critical care needs, but also lacked access to primary care. Thus, patients who lacked access to good primary care had high utilization of resources by seeking care at hospitals' emergency departments.

Varkey et al. (2009) conducted a longitudinal investigatory study examining organizational characteristics, physicians' job satisfaction, and serving minority patients. Using cross-sectional data obtained from surveys given to patients, clinic managers, and primary care physicians, the authors reported that clinics that were serving at least 30% of minority patients displayed a challenging work environment. Varkey et al. argued that clinics that served minority patients were susceptible to significant challenges than those serving fewer minority patients due to existing barriers to accessing resources such as medical supplies and specialty care. Often, these clinics served patients with limited-English proficiency and patients with psychosocial issues, which added to the complexity of their care. These findings supported the authors’ hypothesis of a correlation between serving minority patients and a chaotic organizational environment.

Sommers et al. (2017) argued that to improve patient health outcomes, there must be an improvement in the delivery of care alongside efforts to improve insurance coverage. Researchers conducting a recent study on visit content during PCP visits found that psychosocial issues are less likely to be discussed during a patient visit with PCPs (Santo et al., 2019). Santo et al. (2019) stated that while providers dictated the content of the visit by favoring addressing medically related concerns, patients' priorities were to discuss psychosocial issues. Despite its usefulness, the scholarly work on healthcare quality improvement does not show efforts done by senior healthcare leaders to address short visits with PCPs and the impact they have on patients with low socioeconomic status.

Healthcare Payment System and the 15-20 Minute Visit Policy.

The United States healthcare payment system is multifaceted and complex system. There are four types of physician reimbursement systems: capitation, performance-based, fee-for-service, or a mix of all three types (Sodhi, 2018). According to Getzen (2015), the majority of Americans have health insurance through an employer, the government, or individually purchased health insurance. Getzen wrote that while the government covers approximately a third of Americans with health insurance, the costs are higher because most of these people require more expensive care. Even with this coverage, 50 million people still lack health insurance. Because of the government's huge role in covering costly care, Medicare defines procedures and sets the national standard for how services rendered to patients are reimbursed (Getzen, 2015).

To control the rising healthcare cost, in 1992, Medicare changed the hospital and physician reimbursement method to an RVUs system. The new healthcare payment system paid physicians at a prenegotiated price when doctors billed for patient healthcare services (Hill, 2000). One of the responses to the changes in physician reimbursement has been to increase the number of patient visits per day (Linzer et al., 2015), which has led to reduced duration of office visits with PCPs in primary care clinics (Zyzanski et al., 1998).

In 1997, the Balanced Budget Act passed by the United States Congress focused on programs dealing with public healthcare. There was an emphasis made in the Balanced Budget Act to regulate prices for hospitals, physicians, and other healthcare providers serving Medicare and Medicaid recipients (McClellan, 2011). The Balanced Budget Act contained the most significant spending decrease in the history of Medicaid and Medicare. Parts of the budget cut had new provisions that allowed states to remove the minimum payment standard that was required of them when creating reimbursement rates for healthcare providers. Also, it allowed states to enroll Medicaid recipients in managed care plans that further imposed restrictions on where patients could receive care (Schneider, 1997).

These changes in payment reimbursements have affected how patients receive care. Getzen (2015) stated that despite the code of ethics that requires physicians to provide quality care to all patients, payment types could have an impact on access to care for patients. The author reported on an experiment with 300 physicians that was conducted to see if physicians will accept Medicaid patients. Experimenters called physicians’ offices to request appointments. When patients disclosed that they were Medicaid recipients, almost half of the physician offices declined patients and reasoned that they were not accepting new patients. Other experimenters who were able to obtain appointments after they disclosed their insurance type as Medicaid had to wait a long period to see a physician (Getzen, 2015).

Several researchers have focused on examining how healthcare payment reimbursement methods could impact patient satisfaction, patient health outcomes, and the patient-physician relationship. Recently Liu et al. (2021) evaluated Medicare's Hospital Value-Based Purchasing (HVBP) Program of reimbursing hospitals based on performance. The authors used six different data sources using propensity score matching to estimate the effect of the HVBP Program policy on removing pain management measures from performance reimbursement on patient satisfaction. Liu et al. (2021) explained that the Centers for Medicare and Medicaid Services (CMS) created the HVBP Program in 2010 to improve patient health outcomes and patient experience with care while reducing costs. CMS created the HVBP Program to penalize or reward hospitalists using a total performance score (TPS) to reimburse hospitals based on performance in patient satisfaction and patient health outcomes, among others. Patient satisfaction weighted 25% of the total score, and pain management was part of the patient satisfaction measure. CMS later removed pain management measures from the formula due to concerns that providers were overprescribing opioids to increase patient satisfaction. Lie et al. showed that pain management is essential to patient satisfaction. CMS should find alternative ways to resolve this issue or remove patient satisfaction from the TPS formula. This study highlights the connection between patient satisfaction and the payment system at policy, delivery of care, and cost reimbursement levels.

Guided by the social exchange theory and Rusbult's investment model, Barksdale et al. (1997) examined the patient-physician relationship using a relationship maintenance process model constructed by the researchers. The relationship maintenance process model is determined by the patient's satisfaction, personal relationship with the physician, having an alternative option, and investment in the relationship with the physician. Also, the model examined how these four prerequisites affect patients' commitment to their physicians.

Barksdale et al. (1997) investigated the extent of the patient's commitment to their providers testing how the relationship maintenance process model would work for patients insured through fee-for-service system versus managed care healthcare systems (i.e., HMO, PPO). Results showed a difference in the relationship maintenance process between the two groups. While patients insured through managed health care valued ongoing commitment, fee-for-service patients sought satisfaction and affective commitment. Barksdale et al. noted that the difference between the traditional fee-for-service patients and those insured through prepaid managed care insurance was whether they were restricted to a provider chosen by the plan or if they had the freedom to choose a plan. Thus, this difference could impact the nature of the patient-physician relationship.

The utilization of healthcare resources and services often leads to an increase in costs of care. The rising costs of care and frequent use of high-cost services such as the emergency department for complaints that can be addressed at primary care or urgent care clinics do not yield good health outcomes or high-quality care. Thus, insurance methods of reimbursement take part in a healthcare system that encourages market-based practices that prioritize making money over health equity. Scholle et al. (2005) examined the correlation between the quality of care and utilization. Using data from Health Plan Employer Data and Information Set (HEDIS), Scholle et al. investigated the correlations between quality and utilization among commercial health plan users by measuring two variables: quality and utilization. Utilization was measured based on access to care, emergency department visits, number of days spent in the hospital, and the number of outpatient visits per 1000 members per year. Quality, on the other hand, was measured based on smoking cessation, breast and colorectal screening, diabetes education, and cholesterol control, among other measures. Analysis of the data showed a correlation between utilization measures and an individual quality measure. A statistically significant positive correlation was seen between advising patients to quit smoking and outpatient visits ($r = .22$, $p= .0004$). On the other hand, a negative relationship between emergency department visits and cholesterol control ($r = - .20$, p .00014) was seen. Scholle et al. concluded that statistically significant correlations were found between higher quality care and reduced hospital days.

The fee-for-service model reimburses providers for each service rendered to patients. Thus, the model is a quantity-based payment method because providers are paid more for providing more services to patients. Consequently, the fee-for-service model gives an incentive to provide as many services as possible. Under the managed care model, reimbursement is monthly and not based on the quantity of services patients receive. The idea behind the managed care model of payment reimbursement was to control Medicaid spending. By making a per-patient per-month payment, the system ensures that patients are not receiving medically unnecessary services (Maniam, 2018). While this system worked well in controlling the cost, there is no evidence that the managed care payment model has improved the quality of care to patients, particularly economically disadvantaged patients (Maniam, 2018). The downfall to this system is that if hospitals or physicians feel that patients have exceeded the allowed amount for the monthly reimbursement, they could deny providing needed services to patients. Britton (2015) argued that reimbursing physicians on quantity bases should be partially considered because of the work and energy it takes to provide quality and holistic care.

The cost of healthcare impacts the delivery of care to patients. In the past few decades, there have been changes in the healthcare reimbursement methods and a growing role of managed care in regulating healthcare. In the past, physicians were able to control how much they could charge for visits. The regulations and laws put forth by the United States government, the managed care organizations, and healthcare insurance companies often impact how services are rendered to patients. Physicians are able to see patients only for a short duration so as to see as many patients as possible in a day. Some providers order unnecessary diagnostics (Getzen, 2015). The fee-for-service model and the managed care model did little to address the short visit duration with PCPs.

Facilitating Factors

The current healthcare system design to fix how healthcare is delivered to patients lacks focus on addressing short visit duration with PCPs for populations with low socioeconomic status. A link exists between economic status and health outcomes (Oversveen et al., 2017). Populations with low socioeconomic status experience issues with accessing care due to health inequalities (Weiss & Eikemo, 2017). Healthcare management practices, healthcare reimbursement systems, and technology, among others, are factors that have prevented low-income patients from accessing care.

Healthcare Management Practices.

United States Healthcare leaders continuously search for ways to improve the delivery of healthcare to patients by creating regulations, improving quality of care, enhancing patient safety, and lowering the rising cost of healthcare. Scholarly work on healthcare cost reduction and quality care improvement have shown several significant efforts to improve patient access to care, quality of care delivery, and cost reductions. In 2010 and since the inception of the triple aim framework in 2012, United States healthcare executives have led initiatives promoting innovative strategies that transform the delivery of healthcare. Different healthcare senior leaders have focused on different efforts varying from lowering avoidable readmissions, reducing the use of emergency departments for minor illnesses, care coordination service for chronically ill patients, to improving the health of specified populations. However, quality improvements efforts focused on acute and specialty care improvement and not on quality improvement for primary care clinics (McCarthy & Klein, 2010). Also, improvement efforts have not addressed the short visit durations with PCPs for populations with low socioeconomic status.

Among quality of care improvement works, scholars have documented a focus on providing patient-centered care. Organizations practicing patient-centered care obtained positive feedback from patients who were satisfied with care (Wheat et al., 2018). Riste et al. (2018), evaluated patient-centered care in an integrated care setting. Specifically, Riste et al. explored the perception and implementation of a patient-centered care model among multidisciplinary institutions caring for the elderly population. Riste et al. examined the implementation of a new care model that integrates social services with health services by creating a collaboration effort between social services and health care providing agents serving the elderly population.

Observations along with interviews were made with eight multidisciplinary groups (MDGs) in neighborhoods that were participating in this effort and the staff from three of the MDGs who were at different phases in the implementation of ICP. Several themes emerged from this study: the structures set on the roles and records of staff attending and representing the MDGs' meetings, knowledge sharing among participating staff regarding patient care and other patient-related information, and patients' opinions, perceptions, and feelings on integrated care. Riste et al. (2018) found that MDGs' effort was mainly focused on facilitating the integration piece of the effort. The authors noted that the integration of services made a positive impact on patient care and the ability to provide a holistic care.

Reiter et al. (2014) evaluated costs and benefits of healthcare organizational transformation. The authors identified twelve participants of North Carolina's Improving Performance in Practice (NC IPIP) participants. Secondary data obtained from clinics on changes implemented by practices and clinical outcomes were collected and analyzed. Four domains were identified: patient registries, planned care templates, protocols, and patient self-management support tools. The participating healthcare clinics were identified as an improved organization if two of these four domains were met. Clinical measures were diabetes 5 (D5) score and asthma score. Two main themes emerged from interviews with staffs at the three clinics: personnel time spent by the staff on this project that was not directly compensated, and nonpersonnel resources, such as technology and supply cost. While the cost of IPIP was high, the practices did find the benefits pleasing and related to future return on investment. Despite Reiter et al.'s (2014) effort to highlight the success of the patient-centered care delivery model, the data did not show visit durations with PCPs, nor did researchers examine visit length effect on improving patient health outcomes.

Most of the literature on healthcare quality improvement emphasized care coordination efforts as the go-to guide for healthcare quality improvement in the United States. A recent study conducted by Feltner et al. (2017) underlined the vital role of support staff in providing holistic care to patients. Feltner et al. examined the effectiveness of preventative measures such as the utilization of CHWs and nurses to provide education, assisting patients with system and resource navigation, health coaching, and medical care adherence in rural Kentucky. Participants completed pre- and posttest surveys. Survey questioners collected data on nurse education screening visits, CHW home visits, and clinical outcome measures such as BMI and hemoglobin A1C. Hemoglobin A1C measures the amount of sugar in the blood for the previous three months to evaluate the efficacy of preventative efforts. The variables measured were the effectiveness of the preventative program, empowerment, self-care, and diabetes knowledge. A statistical *t* test was performed to evaluate if there is a significant difference between the pre- and postintervention outcomes. In all variables, a significant difference in the postintervention outcomes was observed.

Feltner et al. (2017) highlights the effectiveness of providing education and coaching to patients. Care coordination emphasizes centering around patient care by creating a team-based model that coordinates care together with the patient. Community health workers (CHWs), PCPs, nurses, and social workers work together to coordinate patient care. Approaching patient care in a holistic matter is essential and requires sufficient visit length. This study did not address the role of PCPs in the care coordination services and potential impacts on patient visit lengths with PCPs.

Electronic Health Rrecords and Visit Length

Information technology has added significant value to the practice of medicine. Tools such as electronic health records (EHR) were developed to replace the old system of paper medical records (Shi & Singh, 2015). Although technology has enabled medical advances in patient care, the use of some technological tools takes time away from what physicians could spend with patients face to face. Hospitals and doctors have been using EHR as a billing tool for services provided to patients in an efficient way that leaves little room for billing error and ensures timely and complete reimbursement.

The idea behind EHR was to enhance the patient-doctor relationship; however, EHR did not fully live up to its potential. Young et al. (2018) examined the effect of EHR use on primary care visit length and concluded that on average, PCPs spent more time on EHR than with patients face to face during the ambulatory visit. Through direct observations of 982 ambulatory patient visits and survey questionnaires, Young et al. found that the average and standard deviation (SD) time spent on caring for patients, excluding precepting time, was 35.8 (16.6) minutes. Of this mean visit length, the authors found that 2.9 (3.8) minutes were spent working on EHR before the physician entered the room, 2.0 (2.1) minutes spent on EHR while in the room with the patient, and 7.5 (7.5) minutes on EHR outside of the visit time. Time spent with patients face to face without using EHR accounted for 16.5 minutes. Young et al. emphasized that using EHRs was associated with physical stress and low job satisfaction.

The original intent of EHR was to enhance the quality of care provided to patients; however, the current use of EHR mainly focuses on billing for services adequately and sufficiently. Sinsky et al. (2016) assessed the percentage of time spent on face-to-face time with patients, EHR, administrative tasks, and other tasks. The objective of the study was to evaluate the impact of EHR on job satisfaction and actual visit length with patients. Through direct observation and self-reported dairies, Sinksy et al. found that physicians spent only 27% of the total clinic hours meeting with patients face to face, and of that time, 52.9% was spent on talking and examining patients, while 37% was spent on EHR and desk work. Also, 49.2% of office days and 1 to 2 hours after work were spent on EHR and desk work. Data from this study indicate that physicians spent more time using EHR than seeing patients face to face, thus leading to physician job dissatisfaction and burnout.

Tai-Seale et al. (2017) conducted a study evaluating physician time allocations using a time functionality tool within EHR. The researchers examined where physicians' effort was most spent. Results of the study showed that physicians spent 3 hours and 17 minutes doing desktop medicine activities such as online prescription refills for patients, ordering lab tests and reviewing test results, responding to patient portal messages, sending messages to staff, responding to medical advice requested by the patient through the online portal, and typing progress notes. Writing progress notes accounted for the primary desktop medicine activity. Physicians experience EHR-related burnout. Physicians spent most of the day typing visit notes and charting on the patients' EHRs. Even though desktop medicine activity such as typing progress note is considered pre- or post-visit patientcare-work, such services were not billable, and insurance did not reimburse for these services. Nonetheless, physicians spend many hours during and after clinic hours typing progress notes. Physicians who had scribers spent less time on desktop medicine and more time with patients face-to-face than those without scribers. Tai-Seale et al. argued that the current physician reimbursement system does not effectively reflect physicians' work. Further, the authors emphasized the need for policy changes to physician payment programs to cover hours spent on desktop medicine.

Contrary to studies linking EHR use to short visit duration, Adler-Milstein and Huckman (2013) showed that physicians at large practices had increased productivity associated with the increased use of EHR and delegating tasks to support staff. The authors assessed EHRs' impact on physician productivity and delegation of tasks and the role of practice sizes on physician productivity. Results showed that there was an independent association between productivity and the increased use of EHR while delegating some EHR tasks to support staff. RVUs were used as a measure of productivity. Despite its usefulness, the literature on EHR does not reveal how technology, particularly EHR, has helped improve patient satisfaction with care, which is an essential aim of the triple aim framework. Further, research on EHR shows that the use of EHR might be a facilitating factor to short visit duration with physicians.

Visit Length and Satisfaction

Scholarly work on patient satisfaction and visit duration with PCPs showed an association between satisfaction and visit length. Lin et al. (2001) studied the relationship between patient satisfaction and perception of clinical office visit length with the primary care provider. Data from a survey on 1486 consecutive ambulatory visits with 16 primary care providers were collected. Survey data collected included demographics, patients' perception of visit duration before and after the visit, and patient satisfaction with care. The results indicated that patients were satisfied with extended visit durations with PCPs. Patients expressed satisfaction with care when they predicted a short visit but had a long visit duration with their PCPs and expressed low satisfaction with care when the visit duration was shorter than expected.

Limiting patient-doctor visit time creates barriers to accessing primary care and disrupts the continuity of care, which decreases the quality of care and lowers physician and patient satisfaction. Dugdale et al. (1999) analyzed previous research on the patient-physician relationship and visit length. The authors evaluated patient satisfaction, outcomes of chronic disease management, prescribing practices, physician satisfaction, and risks of a malpractice claims. In each element of care, Dugdale et al. examined the impacts of patient visit duration on each component of care. Although there was no clear association between visit length and components of care, such as patient satisfaction and health outcomes were found, data showed associations between visit length and other elements such as the risk of malpractice claims, prescribing practices, and physician satisfaction with job. Dugdale et al.'s analysis did not show the direct impact visit length could have on the patient-physician relationship. However, the authors pointed out that factors that can show the contribution to a negative patient-doctor relationship might be due to short visit times.

Anderson et al. (2007) researched the impact of waiting time on patient satisfaction with care. A self-reported survey was given to 5,030 patients. Researchers asked patients to evaluate patients' visits with PCPs, particularly wait times, time spent with doctors, and patients’ overall satisfaction. Patients reported low satisfaction with long wait times and high satisfaction with extended visit durations with PCPs. Physicians have a set time of the day to work and see patients in the office. Since that time is a fixed time, the authors hypothesized that long wait times to see the provider would automatically lead to a shorter visit duration to accommodate waiting patients, thus leading to low patient satisfaction. However, long wait times followed by more extended visits were associated with increased patient satisfaction. Multivariate regression and logistic regression model tests performed to assess the effect of wait time on patient satisfaction showed that long wait times and short visit duration were associated with dissatisfaction with care.

Fostering a culture of open communication allows employees to innovate new ideas (Yahya & Goh, 2002). In a study on voice climate and patient satisfaction association done by Nembhard et al. (2015), the researchers found that the organizational voice climate was significantly associated with patient satisfaction. Nembhard et al. explored the relationship between employees’ perception of organizational climate and patient satisfaction. In particular, the researchers focused on voice climate (i.e., employees' perception of being heard and listened to when they had concerns and ideas) and patients' timeliness of care (i.e., how long it takes for a patient to see a physician, obtain follow-up care such as lab results and follow-up appointments; and see a doctor as soon as needed). Nembhard et al. surveyed organizational climate impacts on patients' experience and satisfaction with care. The results from their study indicated a statistically significant relationship between voice climate and patients' timeliness of care.

Gap in the Literature

Scholars in healthcare management have found that the 15-to 20-minute visit duration with PCPs might have an impact on quality of care (Abbo et al., 2008), patient-physician relationship (Dugdale et al., 1999), patient satisfaction with care (Geraghty et al., 2007; Gross et al., 1998), and physician satisfaction. However, these findings did not address the impact of the 15-to 20-minute visit duration on patients with low socioeconomic status. Phelan et al. (2010) reserach on health disparities showed that economically disadvantaged patients lack access to care and suffer from health issues as a result of their social condition. The efforts done by United States Senior healthcare leaders to fix the healthcare system for all patients have been well documented by healthcare system scholars and researchers. Yet much of the research on healthcare quality improvement has focused on improving care for the elderly, to reduce the number of avoidable readmissions, enhancing care for patients with chronic conditions, or reducing healthcare costs.

Despite decades of attention to the visit duration with providers and implications for a patient-physician relationship, the research tells us little about the lived experience of patients with low socioeconomic status, PCPs, and healthcare administrator leaders in low socioeconomic background patients with the 15-20 minute visit duration with PCPs. We know little about the perceptions of the three stakeholders on the 15-20 minute visit duration with PCPs. Through this proposed qualitative multiple case study, I gained an insight into the common understandings economically disadvantaged patients, PCPs, and healthcare leaders serving patients with low socioeconomic have on the 15-20 minute visit duration with PCPs.

Research Methodology Review

A qualitative multiple case study design was chosen for this study. Qualitative methodology is used when researchers are interested in exploring topics to gain an understanding of individual's perception, experiences, behaviors, and approach to the phenomenon of interest (Merriam & Tisdell, 2016). Qualitative research has been used in business and healthcare studies (Cabtree & Miller, 1999; Eriksson & Kovalainen, 2008). In healthcare studies, qualitative research is used to understand patients' view of the care provided. In primary care research, qualitative studies have been traditionally used to explore patients' experience with care.

Smith and Firth (2011) examined the qualitative framework approach and pointed out that qualitative methodology is a valuable method of data management in healthcare research that seeks to find out about the patient experience with care. In the field of pharmacology, Sutton and Austin (2015) noted that even though qualitative research design is not widely used in the healthcare sector, it is a useful method to explore patients' experiences with care and treatment. In particular, in pharmacy studies, qualitative research allows the researcher to know the behaviors of patients, especially in the area of nonadherence to medication. Sutton and Austin urged researchers to be particularly aware of their own biases and to document researchers' reflections of biases. This study was useful in exploring patients' understanding of visit length duration and the impacts of that on their satisfaction with care.

An exploratory multiple case study design was chosen for this study. Case study research is used to examine a case or multiple case in an in-depth and detailed matter (Yin, 2018). Baxter and Jack (2008) described a case study as a unit of analysis that emphasizes the context. Baxter and Jack highlighted the importance of evaluating the context in which the case is being studied. The authors used an example of a case study regarding how nursing students make decisions and defined the case as the decision making while emphasizing on the context of this decision making which is the nursing school. The authors pointed out that the context of the case being studied would help the researcher determine if the case should be a single case or a multiple case study. Through an approach of a multiple case study design, I gained an insight into how patients with low socioeconomics, PCPs, and healthcare administrator leaders have experienced the 15-20 minute visit duration with PCPs.

Summary and Conclusions

The management problem this study addressed is that the 15-20 minute visit with primary care providers does not leave sufficient time to address healthcare concerns and psychosocial issues of patients with low socioeconomic status. Many of the studies on visit duration in the past decade have shown an increase in patient health and psychosocial concerns that are not reflective of visit length with PCPs. Abbo et al. (2008) investigated several complaints patients presented during the visit with PCP and visit length. Data obtained from the National Ambulatory Medical Care Survey were analyzed for the years 1997 to 2005. Statistical analysis for the data from this period showed an increase in the number of topics discussed during primary care visits from 5.4 to 7.1 in that period. Meanwhile, a slight increase in the visit time from 18.0-to 20.9-minutes was observed. Thus, Abbo et al. argued that while the number of issues discussed during office visits with primary care providers has increased, the visit length is not reflective of that increase.

The purpose of this qualitative exploratory multiple case study was to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the 15-20 minute visit with PCP in primary care clinics. In this chapter, I reviewed the scholarly work on the triple aim conceptual framework and provided an insight into how I used this framework to guide this study. Through a review of the literature, I analyzed previous and recent scholarly work on healthcare quality improvement efforts, the relationship between the healthcare payment system and short visit duration with PCPs, visit length and patient satisfaction with care, EHRs’ role on visit length with PCPs, and health disparities among other topics. I addressed the gap in the literature and reviewed the literature on the chosen methodology for the study.

Chapter 3: Research Method

The purpose of this qualitative exploratory multiple case study was to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the 15-20 minute visit with PCP in primary care clinics. Chapter 3 includes a description of the research design and rationale of the study, the role of the researcher, an in-depth methodology review, and issues of trustworthiness. In this chapter, I provided a detailed description of how I conducted the study. Further, I conveyed the rationale behind the chosen methodology and reasons the selected method is the best for the topic of interest. I provided a summary of the chapter and introduced Chapter 4 in the summary section of this chapter.

Research Question

What are the common understandings from patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders about of the 15-20 minute visit with PCPs in primary care clinics?

Research Design and Rationale

The average patient visit length with PCP is 15-20 minutes (Migongo et al., 2012; Tai-Seale et al., 2007; Young et al., 2018), which is not enough time to provide evidence-based that is patient-centered care particularly for patients who are economically disadvantaged (Fiscella & Epstein, 2008). I chose to conduct qualitative research for this study to gain an understanding of the lived experiences of patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders with the 15-20 minute visits with PCPs in primary care clinics. Denzin and Lincoln (2005), as cited by Aspers and Corte (2019), defined qualitative methodology as an approach to research in a naturalistic setting that involves an understanding of the meanings, and the interpretations people make of a phenomenon. Historically, qualitative research has its roots in the social science disciplines, particularly sociology, anthropology, and psychology (Hooker, 2010). In the business and management field, there has been an increased interest in the use of qualitative research in order to attain a deeper understanding of the lived experience of consumers, employees, or managers with a business, and management-related phenomena (Cassell et al., 2018).

Quantitative methodology has been and continues to be the gold standard for conducting clinical research. However, qualitative methodology research has been useful in understanding patient experience with care. Qualitative research is used in health research to collect data from participants that goes beyond numbers and variables to gain a deep understanding of patient behavior, experience, attitude, and connection to treatment and overall care (Hammarberg et al., 2016; Pathak et al., 2013). Qualitative researchers answer questions investigating participants' experience, meaning, and perception on the topic of interest (Hammarberg et al., 2016). Qualitative inquiry is the most appropriate method for this study to understand the meaning PCPs, healthcare administrative leaders, and patients with low socioeconomic status make of the 15-20 minute visit duration with PCPs in Minnesota primary care clinics.

Quantitative research designs are systematic investigations that are objective and rely on numerical data (Guest et al., 2013), and are used when researchers are interested in obtaining factual data on participants' attitudes, views, opinions, and beliefs that can be generalized to the larger population. Key characteristics of quantitative inquiries include a large sample size (>50) that can represent the population, numerical analysis, and statistical, mathematical, or computation measurement of the data collected (Clark & Creswell, 2015). Quantitative methodology approaches are experimental or descriptive. The goal of using quantitative methodology is to collect and analyze quantifiable data that can be generalized to a broader population (Yilmaz, 2013). I considered a quantitative methodology for this study. However, to gain an understanding of how patients, PCP, and healthcare managers experienced the visit duration with PCPs, a qualitative methodology was more appropriate method.

Role of the Researcher

When conducting qualitative research, the role of the researcher as the primary data collector is to observe, evaluate, examine, and conduct the study. The researcher is instrumental in constructing meanings; the researcher needs to be aware of his or her role (Given, 2008). My role in this study was the interviewer and research analyst. I interviewed 15 participants who were identified as five individuals who were patients with low socioeconomic status, five primary care providers servings patients with low socioeconomic status, and five healthcare administrators at safety net clinics.

My interest in this study developed from my previous work experience providing care coordination services to patients with low socioeconomic status. While working with these patients as a care coordinator, I observed and received feedback from patients who expressed some level of dissatisfaction with clinic-based visit duration policies. Due to my previous experience working with low-income patients at primary care clinics in Minnesota, I bring certain biases to this study.

Biases, based on past and current personal and professional experiences, as well as demographics, can be managed by being reflexive (Dowling, 2006). Researchers can reflect on how their bias might shape the research by taking notes during the research process. Researchers use reflexivity to focus on the researcher's ability to eliminate biases and to reflect on the potential impact of existing biases on the study (McCabe, & Holmes, 2009).

To ensure objectivity and to avoid my biases, I used reflective journaling. Researchers use reflective journaling to make meaning and to be aware of emotions and thoughts in any moment. Using data triangulation limits biases in the study. I researched publicly available secondary sources from government agencies to achieve data triangulation.

Methodology

Qualitative inquiry encompasses a range of approaches including ethnography, grounded theory, phenomenology, narrative research, and case study. The qualitative case study design is used to understand a phenomenon within its real-life context (Smith, 2018), can be single or multiple (Yin, 2018), and can be an investigation of an individual, group, event, or organization (Baxter & Jack, 2008). Case studies are exploratory, explanatory, or descriptive. Case study designs include multiple sources of data. I chose a multiple exploratory case study design for this study to gain an understanding of the lived experiences of patients with low socioeconomic status, PCPs caring for these patients, and healthcare administrative leaders managing clinics that serve these patients with the 15-20 minute visit duration with PCPs.

I conducted a multiple case study to explore each of the groups' lived experiences with this 15-20 minute visit duration. I used this approach to understand the issue of short visits with PCPs from the patients' perspective. It is also essential to know how PCPs serving patients with low socioeconomic status experienced short visits with patients. Finally, gaining an understanding of the healthcare administrative leaders' at clinics serving patients with low socioeconomic status experience with the 15-20 minute visit with PCPs provided a helpful insight onto visit polices in place for clinics serving patient with low socioeconomic status.

I considered a phenomenological research design; however, it was not appropriate for this study. Phenomenological studies are used when researchers are interested in understanding the lived experiences of individuals who share a similar or shared experience (Norlyk & Harder, 2010). In this study, I collected data from different stakeholders of the 15-20 minute visit policy with the primary care who do not share a common experience. Thus, a phenomenological approach was not appropriate for this study.

Participant Selection Logic

Participant sampling in qualitative research is strategic, and individuals are deliberately selected because they fulfill the criterion specific to the case that is being studied (Maxwell, 2009). This qualitative case study involved a purposively sampled minimum of 15 participants until saturation was reached. Five participants were identified as adult patients, aged 18 years or older with low socioeconomic status, five were PCPs at clinics serving low-income adult patients, and five were healthcare administrative leaders managing the above-stated clinics. In qualitative research, generalizability is not required, and the small sample size of a study is deliberately selected rather than developed at random (Burkholder et al., 2016).

After obtaining Walden's Institutional Review Board (IRB) approval, I began the recruitment process. I recruited participants by posting flyers of the study on social media outlets, specifically Facebook and LinkedIn. I also posted a recruitment project on userinterviews.com and Walden Participants Pool. Participant criteria were: 18 years old or older low-income patients who had or has a primary care provider, PCPs providing care to low-income patients, or clinic administrators at clinics serving low-income patients. I used Walden Participant Pool to recruit clinic leaders only. I did not collect demographic information such as, gender and race as this information were not part of the data needed to answer the research question, and it would not have been helpful for data analysis. Forty-three participants responded to my recruitment, and a total of 15-participants were selected to be interviewed. Before conducting interviews, I sent a consent email to each participant explaining the interview procedure, voluntary nature of the interview, risk and benefits of being in the study, privacy, any compensation, and contact information for any questions or concerns. I asked participants to respond to the email stating that they consent to partake in the study.

To further screen participants who are patients, I collected demographic data about insurance type and income status. PCPs and clinic managers were asked in the screening questions if they worked at a clinic that served low-income patients or if their patients were low-income patients. Patients self-identified themselves as low income. As part of the screening questions, I asked patients if they have a PCP whom they see regularly.

Instrumentation

Research instruments are tools used by the researcher to collect data. In qualitative studies, the researcher is the instrument. Researchers use interviews to gain insight into the participants' lived experiences with a phenomenon (Merriam & Tisdell, 2016). Interviews are useful to participants and researchers. Participants openly convey their thoughts and feelings. Researchers then can follow up by asking probing questions. Through interviews, researchers can collect an enormous amount of data in a small amount of time.

I conducted qualitative in-depth, semistructured virtual interview via Zoom with 15 participants. I audio-recorded the interviews. I took notes of participants body reaction and documented my thoughts and feelings prior, during, and post data collection. The data collected were all from the interviews I conducted with the 15 participants. I developed interview questions based on the research question, conceptual framework, and the literature review on the 15-20 minute visit duration with PCPs. The interview questions were open-ended questions to allow the participants to respond to the questions and express their thoughts, opinions, and experiences with the phenomenon wholly and openly. Interviews are useful to participants and researchers. Participants openly convey their thoughts and feelings.

Interview Protocol

For the interviews in this study, using the Walden University Center for Research Quality guidelines, I created the interview protocol (Appendix A). An interview protocol is a plan on how the researcher will conduct the interview, procedures the researcher will follow, and interview questions (Castillo-Montoya, 2016). In qualitative research, researchers document participants' responses by using different mediums such as videotaping, audiotaping, and by taking handwritten notes even while the interview is being taped. The interview protocol contains interview questions and specific guidelines that I followed at the beginning of the interview. I introduced myself to the participants, restate the purpose of the research, and address privacy concerns. I stated the interview procedure, risks, and benefits of participating in the study. Participants could withdraw from the study at any time, and I would not use any of their data. I informed participants of the length of the interview, and upon completing the interview, I transcribed all data. I sent the transcribed interviews to participants for their approval.

Documents

In addition to the primary data collected through interviews with participants, secondary data was analyzed in qualitative studies (Marshall & Rossman, 1995). I researched publicly available secondary sources from government agencies, such as Center for Medicare and Medicaid services (CMS): Research Data Assistance Center (ResDAC), Agency for Healthcare research and Quality, and the Center for Disease Control and Prevention (CDC) and specifically looked at data available at the National Center for Health Statistics, CDC's Data and Statistics databases, and The National

Hospital Ambulatory Medical Care Survey (NHAMCS). Through Walden University library databases, I researched related sources from Public Library of Science (Plos) and the Inter-University Consortium for Political and Social Research (ICPSR). According to Marshall and Rossman, in qualitative studies, researchers use document analysis as part of the content analysis. Content analysis involves objectively evaluating the patterns of organizational communication and documents. I used secondary data analysis as a means of triangulation to draw from two sources of evidence.

Field Notes

Field notes are an integral part of a qualitative research design. Researchers used field notes to document observations, feelings, and thoughts while conducting the interview (Rubin & Rubin, 2012). I took field notes that was part of my journal during the interview and documented interviewees' nonverbal emotions, behaviors, and attitudes. Further, I took notes depicting my thought processes.

Procedure for Participation and Data Collection

I recruited participant by posting flyers of the study on social media outlets, specifically Facebook and LinkedIn. I also posted recruitment projected on userinterviews.com and Walden Participants Pool. Data were collected from 15 participants. I did interviews virtually, via Zoom with patients, PCPs, and healthcare administrative leaders. Before data collection, I emailed individual consents to participants. Participants were reassured that they can make a withdrawal from the interview and the study at any time, and if they do withdraw from the study, none of the collected data would be used.

The interview protocol contains detailed information on debriefing procedures, follow-up procedures, and requirements to return for follow-up interviews. Before starting each interview, I discussed the interview procedures, follow-up interview requirements, and procedures. During the interview, I did a follow-up on questions and seeked clarification when it was appropriate. I reassured participants that data collected were only be used for this study and will not be shared publicly. At the end of the interview, I thanked participants, ask if they have any questions, and notified them that I will send the transcript of the interview.

I conducted one-on-one interviews with each participant. Interviews were audiotaped to eliminate errors and accurately transcribe the participants’ interviews. Every interview was scheduled to take 1 hour, and the entire data collection lasted no more than 4 weeks. Interview data was transcribed after the interview. I shared transcription of the interview with each participant for accuracy. I asked participants to respond to me within 48 hours to acknowledge that they have received the transcript. After 1 week of not hearing from participants, I moved on to data analysis and assume that participants approve of the transcript.

Data Analysis Plan

Data for the 15-20 minute visit duration with PCPs were primarily collected employing in-depth interviews. I constructed open-ended interview questions that covered several substantive areas. I drew interview questions from the research questions, conceptual framework, problem statement, significance of the study, and the gap in the literature.

Qualitative data analysis is not a linear process and can be time consuming and confusing. Data analysis involves establishing a systemic process that involves organizing the collected data into a meaningful result (Marshall & Rossman, 1995). Upon completing the individual interview, I transcribed the interviews and put the input into a computer program called NVivo for data analysis. NVivo is a software program that facilitates the analysis of in-depth interview data, memos, and observations, among other information (Babbie, 2017). Computer software programs such as NVivo save time for researchers and accomplish an essential aspect of data analysis by assigning codes to the transcript data. Codes are short phrases or words generated by the researcher that give meaning to a specific statement made by participants (Saldana, 2016).

After the initial coding done by NVivo software, I performed the actual data analysis and review categories and themes that emerge from the interview data. I created findings based on themes emerging from the interviews along with analysis of other secondary data sources. I anticipated that the process of analyzing data could take up to 3-8 weeks, and then I began to write the findings. I reviewed and explained any discrepancies found within the data.

Issues of Trustworthiness

Credibility

Researchers employ internal validity to ensure that the study is believable, the data collected are trustworthy, and that they are reflective of the research questions (Meijer et al., 2002). I established internal validity by using multiple approaches such as member checking, data triangulation, and reflexivity to enhance my ability to evaluate the accuracy of the study findings. I used publicly available secondary sources from government agencies to achieve data triangulation. I provide copies of the interview transcripts after the interviews, and my interpretation of the interviews after the data analysis for member checking.

Transferability

External validity or transferability deals with evaluating if the study findings can be generalized and applicable to other studies (Yin, 2018). My study addressed the social problem that the institution of the 15-20 minute visit duration created unexpected adverse outcomes to achieve administrators' triple aim framework for patients with low socioeconomic statuses. Guiding this study by the triple aim framework, I hoped this study will speak about the general issue of health disparities.

Dependability

Dependability is particularly critical in qualitative research; it ensures that there is a consistency in gathering, examining, and reporting data (Burkholder et al., 2016). Dependability ensures other researchers can obtain similar results if they duplicate the study. My approach to achieving dependability was by triangulation of multiple data sources to ensure that the study findings are accurate. By including all data collected from interviews and publicly available secondary data, I could check the data against each other. I carefully reviewed and reported if I found any discrepancy in the data.

Confirmability

Confirmability is achieved by separating the researcher's bias from the study. I was aware of my own bias by keeping a journal where I notated my thoughts, beliefs, and emotions as I conducted the study, particularly while conducting interviews. As a former care coordinator, I brought in assumptions about what visit duration should be for patients. These assumptions could be present while at the site of the interview. It was essential that I accurately report participants' experience with the 15-20 minute visit duration. Further, I utilized peer-debriefing during my data analysis.

Ethical Procedures

Conducting research on human subjects raises ethical issues that must be addressed before doing the study. The researcher needs to be particularly aware of the inevitable biases he or she brings to the study by being cautious of his or her beliefs, values, and preferences. I was aware of my role as researcher and the bias I could have brought to the study. Before conducting the study, I obtained institutional permission from the Institutional Review Board (IRB) at Walden University to conduct this study, IRB approval number: 01-27-21-0506894. I obtained written consent from participants before the interview by emailing participants IRB approved consent from and requesting a reply with I consent.

I conducted all interviews with participants in a private room with a locked door. To ensure participant privacy is protected during the interview, I was the only person in the room. The audio of the interview was at a level that I can only hear in the room. Participants did not know each other and were recruited separately. For instance, patients of physicians I interviewed, were not required to participate in the interview and the same was true for physicians as well. Volunteers' identities were kept confidential. Only I (the interviewer) knew the real names of participants and did not share with anyone else. Participants' privacy will be protected by destroying collected data after five years from the study completion per Walden University's requirement. I was the only one with access to the collected data.

Summary

Chapter 3 contained information regarding the study method and design, research question, the role of the researcher, methodology, and issues of trustworthiness. I provided a general overview of the research design and rationale. The research methodology section of the chapter was described in detail by reviewing participant selection logic, instrumentation, procedures for recruitment, participation, data collection, and data analysis plan. In the last section of the chapter, I described strategies and approaches to ensure credibility, transferability, dependability, and confirmability. I also provided an overview of how I will address any ethical issues.

Chapter 4: Results

The purpose of this qualitative exploratory multiple case study was to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the15-20 minute visit with PCPs in primary care clinics. Interview questions explored how each stakeholder of the 15-20 minute visit duration with PCPs have experienced this visit duration. Relatively little, however, is known about the 15-20 minute visit duration with PCPs and how each of the three stakeholders has experienced with this visit duration.

The research question serves to provide direction for developing the study. To achieve the study's goal, aligning the research question with both the problem statement and the purpose statement is critical. The research question explored in this study was: What are the common understandings from patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders of the 15-to 20-minute visit with PCPs in primary care clinics? I asked interview questions aligned with the research question, conceptual framework, problem statement, and past literature on this topic.

In Chapter 4, I describe the research setting demographics of the participant and provide details on the data collection methods I used. Next, I analyze the data collected by reporting on my coding process to create categories and themes. Other sections in chapter 4 include evidence of trust worth and a detailed discussion of the study result. I will conclude this chapter by providing the summary section where I will answer the research question.

Research Setting

I conducted the interviews with participants in a private room with a locked door at my home. To ensure participant privacy was protected during the interview, I was the only person in the room. Participants were in their offices or at home. I arranged the interviews during times that worked for the participant and accommodated their needs. Participants did not share, and there was no indication from their responses of any adverse effect related to the interview setting that might have influenced the study interpretation and the outcome of the study results.

Demographics

I recruited a purposively sampled minimum of 15 participants. Five participants were identified as adult patients, aged 18 years and older with low socioeconomic status. Five were PCPs at clinics serving low-income adult patients, and five were healthcare leaders managing clinics that serve low SES patients. Patients were allowed to determine if they consider themselves low-income or not. All participants were asked types of insurance they had or accept in the demographic's sections of the interview questions. All PCP and healthcare leaders indicated that they accept Medicaid insurance or cared for patients with low SES backgrounds. All patients' participants stated they had Medicaid and some Medicare along with Medicaid or other state-funded insurances, thus confirming that all participants were either Low SES patients or were PCPs or clinic managers that served.

After obtaining Walden’s IRB approval, I began the recruitment process. I used userinterviews.com, Walden participants pool, and social media outlets such as LinkedIn and Facebook to recruit participants. I used Walden participant pool to recruit clinic leaders only. I did not collect demographic information such gender and race as this information were not part of the data needed to answer the research question, and it would not have been helpful for data analysis.

Data Collection

Upon Walden's IRB approval, I began the recruitment process. I posted flyers of the study on social media outlets, specifically Facebook and LinkedIn. I also posted recruitment projected on userinterviews.com and Walden participants pool. I used Walden participant pool to recruit clinic leaders only. Forty-three participants responded to my recruitment, and a total of 15 participants were selected to be interviewed. Before conducting interviews, I sent a consent email to each participant explaining the interview procedure, voluntary nature of the interview, risk and benefits of being in the study, privacy, any compensation, and contact information for any questions or concerns. I asked participants to respond to the email stating that they consent to partake in the study.

Before starting each interview, I reviewed the debriefing procedures, follow-up procedures, and requirements to return for follow-up interviews. During the interview, I asked follow-up questions and sought clarification when appropriate. I reassured participants that the data collected would only be used for this study and would not be publicly shared. Further, I reassured participants that they could withdraw from the interview and the study at any time, and if they had withdrawn from the study, none of the collected data would have been used in the study. At the end of the interview, I thanked participants, asked if they had any questions, and notified them that I would send the interview transcript within 72 hours.

I conducted one-on-one semistructured interviews virtually, via Zoom, Facetime, and over the phone with 15 participants; five patients of low SES, five PCPs to low SES populations, and five healthcare administrative leaders. I audiotaped interviews to eliminate errors and to transcribe accurately the participants' interviews. Interview durations lasted 20-60 minutes, and the entire data collection process lasted a month. Interview data were transcribed after the interviews and shared with participants

I wrote chapter 3 and received the proposal approval before COVID-19 restrictions. The unusual circumstances of COVID-19 infection control and mitigation affected the original data collection plan presented in Chapter 3 and created a variation in data collection. The initial plan included reaching out to five clinics that served Medicare and Medicaid populations in Minneapolis, MN. These potential sites of the study were a federally qualified healthcare center that provides medical, dental, mental health, and social services to underserved populations in North Minneapolis, three clinics in South Minneapolis that served Medicare and Medicaid populations. Two of the clinics decline my request to collect data from their patients, PCPs, and healthcare administrative leaders due to COVID-19 restrictions. Both sites stated that they were at capacity with other studies. The other three clinics did not respond to my request to conduct the study at their clinics.

Data Analysis

I audio recorded all the interviews using the voice memos application on MacBook Pro and transcribed all the interviews verbatim. Copy of the transcripts was shared with all participants for accuracy check. In the analysis of the interview transcripts, the goal was to capture the shared experiences of the three stakeholders of the 15-20-minute visit duration. During the interview transcription, I assigned a unique ID number to each transcript to ensure that this data did not trace back to the participant. I began the data analysis process by uploading all 15 transcription interviews into NVivo software. The first step in data analysis was coding to familiarize me with the data by listening to the transcription. I then read the interview transcripts line by line and documented my thoughts and feelings.

I utilized inductive and deductive approaches to achieve thematic analysis. Employing an inductive coding process, I applied several coding strategies to understand participants' lived experiences with the 15-20 minute visit duration with PCPs. I used initial coding, descriptive coding, In vivo coding, holistic coding, sub-coding, simultaneous coding. I then assigned words to each sentence and passages that best represented participants' perceptions. Each method used allowed me to identify relevant statements to answer the research question. Further, I used a deductive coding process by identifying what parts of participants' data were relevant to the research question, conceptual framework, interview questions, and analysis of the literature and documented potential themes, categories, and codes.

During the coding process, I paid particular attention to patterns in the data, mainly shared perspectives among participants. At the end of the initial coding cycle, I identified 151 codes. After completing the initial coding cycle, I sorted the codes and grouped similar ones into categories. During this process, I reviewed initial codes and made changes by adding, deleting, or renaming some of the codes. I continued to review and make changes until I determined the codes represented the categories and themes that represented participants' experiences and perceptions of the 15-20 minute visit duration. Seventy-five codes were identified towards the end of the first cycle of coding. Table one summarizes major themes and categories from the study findings.

Table 1

Themes and Categories That Have Emerged from the Study

Major Themes	Healthcare management Practices	Healthcare Payment System	Patient and Physician Satisfaction	Patient Care	Patient Visit with PCP	Patient-Physician Relationship
Categories	Barriers	Cost of care	Patient Satisfaction	Attending to the patient	Efficiency	Communication
	Clinic Role	Equity in Patient Care	Physician Satisfaction	Care team	Visit Content	Develop a repour
	Systemic Issues	Payment System		Good care	Visit Duration	Family
				Healthcare outcome	Visit Frequency	Good Relationship
				Patient Type	Visit time sufficiency	Knowledgeable
					Waiting Time	Length of relationship
						PCP Accessibility
						PCP Personality
						Trust

After identifying the codes, I started sorting the data and created categories and themes based on the relationship between the codes, frequencies in which codes appeared, and any meanings between the codes. I looked for codes that referenced a specific concept. For instance, a group of codes referenced the concept of visit duration. First, examining participants' perception of the average visit duration, I analyzed responses to the interview question inquiring directly about the average visit duration with PCPs. I developed several codes to appropriately label Participants' responses. Twelve out of 15 participants reported that the average visit duration with PCPs was 15-20 minutes or close to that time frame; I coded this under 15-20 minutes.

A subcategory of the visit duration referenced participants' perception of long visit duration. Thirteen out of 15 participants expressed that visit duration length should be long, and some gave a specific number of minutes such as 30 or 45 minutes long. I labeled longer visit spots for participant responses that spoke of participants' views on visit length. Patient participant four expressed her wishes for a more extended visit spot. "So, I do understand the rules sometimes; I just wish that maybe they have longer spots blocks. Because sometimes you wait a long time for a doctor's appointment, sometimes you have to wait like almost 30 days or something to get seen, especially when it is a dentist appointment yeah, they book way out." I coded this passage under longer spots. Thirteen out of the 15 participants were coded under the more extended spot code to capture participants' experience and view of more extended visit spots. A PCP participant explained visit length with patients and how it varies. However, the PCP highlighted that the visit length was greater than 20 minutes:

> well I think the it's close to 30 minutes some people get 40 um I run behind, um because we talk, um internal medicine we ask questions were more detail oriented the same time you you you uh yeah so we talk to our patients so I'd say most of the time they say the shorter end is 20 minutes for some patients that everything is going well, that's probably the shorter end 'cause there's talking about how they're doing just in general how are you doing anything else happen any questions you have now let's get down to business you know so 20 minutes goes by pretty quickly for an easy patient and most patients they say 30 minutes and some 40 to 45 minutes but by 45 minutes that's enough 'cause again you can only do only so effective so um so there's a little bit of a range between 20 and 45 minutes but 30 minutes is uh pretty good for a lot of people face to Face Time.

Healthcare management leader participant also explained longer spots to be booked for every patient care. Participant stated:

> if you could you have a 40 minute visit with every patient almost every patient I would say I would say 40 minutes would be the average and and you'd sometimes book a 40 minute visit and then what would happen is either it would take the full 40 minutes and would be great I had it or you or it would take maybe 20 minutes and you have 20 minutes to actually finish all the documentation so you wouldn't have to be doing it later so that would be my ideal but nobody there's no payer system that's going to support that right now.

Other participants shared their experiences with visit duration that were longer than the 15-20 minutes or the need for longer visit length.

Evidence of Trustworthiness

Credibility

The validity process ensures that study results are accurate and reflective of the data collected (Creswell & Creswell, 2018). I used internal validity to ensure that the data collected is trustworthy, reflective of the research question, and that the study is believable by member checking and data triangulation. To check if I accurately captured participants' experience with the 15-20 minutes, I provided copies of the interview transcripts, the transcription, initial coding, and themes that emerged from the interview and asked participants to confirm if my interpretation was accurate.

To achieve data triangulation, I researched publicly available secondary sources from government agencies, such as the Center for Medicare and Medicaid Services (CMS): Research Data Assistance Center (ResDAC), Agency for Healthcare Research and Quality, and the Center for Disease Control and Prevention (CDC) and specifically look at data available at the National Center for Health Statistics, CDC's Data and Statistics databases, and The National Hospital Ambulatory Medical Care Survey (NHAMCS). I researched related sources from the Public Library of Science (Plos) and the Inter-University Consortium for Political and Social Research (ICPSR) through Walden University library databases. My original plan for data triangulation was to request documents from organizations such as meeting minutes, visit policies, and patient surveys. Unfortunately, due to COVID-19 restrictions, I could not partner and conduct interviews with any identified organizations in chapter 3.

Transferability

External validity or transferability deals with evaluating if the study findings can be generalized and applicable to other studies (Yin, 2018). The focus of this study was the social problem created when senior healthcare leaders implemented the 15-20 minute visit with PCPs as the standard office visit time for primary care patients representative of a low socioeconomic environment. In this study, because of the triple aim framework, the aim of this study was to help to clarify the general issue of health disparities. The study's findings highlighted the issues of healthcare disparities and how the three stakeholders of the 15-20 minute visit duration have experienced this visit length with PCPs. Following the research methodology and design used in this study, other researchers can further study this issue.

Dependability

My original approach to achieving dependability was to include organizational documents and interview data. Due to COVID-19 restrictions, I could not partner with identified healthcare centers in Chapter 3. Thereby, I researched publicly available secondary sources from government agencies to achieve data triangulation. I looked for themes and concepts related to primary care consisting of the following keywords: Healthcare management practices, healthcare payment system, patient and physician satisfaction, patient care, patient visit with PCP, and the patient-physician relationship. I ensured the study findings were accurate by triangulating multiple data sources.

Confirmability

I achieved confirmability by being aware of my biases. Throughout the data collection and analysis, I kept a journal writing down my thoughts, beliefs, and emotions. Further, I utilized peer-debriefing during my data analysis to check if I accurately interpreted participants' experiences.

Study Results

The research question addressed in this study is: What are the common understandings from patients, healthcare providers, and healthcare administrative leaders of lower socioeconomic backgrounds about the 15-20 minute visit with PCPs in primary care clinics? The research question served to provide direction for the development of the study. Drawing the research questions from the problem statement and purpose statement ensured alignment in the study. Interview questions were based on the research question, significant themes in the literature review, conceptual framework, and purpose of the study. Fifteen participants were interviewed for this study. As shown in Table 1 above, I identified six themes from the data collected. After the first coding cycle, I sorted the codes by putting them into categories and further into themes based on the relationship between codes.

Theme: Healthcare Management Practices

The theme healthcare management practices emerged from participants' thoughts and experiences on how specific micro and macro healthcare management impacts patient care, patient visit duration, patient satisfaction with care, physician satisfaction with job and patient care, and the overall healthcare system. I sorted codes under this theme into three categories: barriers, clinic role, and systemic issues. These categories captured participants' perception of how management created issues that directly and indirectly impacted patient care and what is needed to address these issues.

The category barriers to care were based on the participants' information about barriers they have experienced or perceived as barriers to patient care. One of the patient participants expressed a lack of direct access to PCPs and identified barriers to receiving adequate care. "You find that some primary care providers are not all of that friendly, they don't want to become accessible, and they are restricting, and you have to call direct the I don't know the office, maybe it is an assistant that so that might create some barrier before something can add to the situation that maybe a situation that made it tough so yeah."

A healthcare manager participant explained that financial, transportation, and lack of knowledge on navigating the system are barriers patients face when trying to access primary care clinics. Thus, he noted that these barriers lead to frequent emergency department visits.

> So, there's very many frequent flyers. I know probably 15 on hand their first and last name and what they'll come in for every single time. What we typically do is we have a social worker in house in the Emergency Department seven days a week nine to five and they basically do all types of things to try to get them either placed in a nursing home if that's what is needed or to call the community clinic to get them an appointment as well as taxi rides there from their house so they schedule a lot of appointments. The barriers that I think people face whenever

> they're trying to actually get to an appointment whether that be simply the knowledge or having the money to have a cell phone to call the office, the money to get to the point because of a car as well as just the lack of knowledge and you know how to follow up on what time and how to set those things up.

Other barriers participants brought up included barriers to obtaining medication discussed by a PCP participant and barriers that deal with navigating the healthcare system due to language barrier, transportation, and medication, among others.

More than half of PCP and healthcare administrative leaders expressed concerns with psychosocial issues and their impact on patient health. One PCP participant explained that psychosocial issues are time-consuming and not always directly addressed, stating:

> I would say uh let's say about 1/5 of the time if you said average 'cause number one people don't bring it up directly, but it impacts it impacts everything else and so it's almost backwards just like when people aren't taking their medicines it might be psycho or social or both issues. They’re able to get transportation regularly, they don't have the copay, they don't want to pay, you know like the medicines or suspicious of the medicine. So let us say psychosocial things impact the rest of the stuff we're doing that half hour it slows it down it makes it more confusing it makes me um ask more questions to get more clarification and dig deeper um so that's it's interesting the psychosocial isn't like a direct discussion it's it's it's impacting the health needs in general in multiple ways and you know um so I'd say when it's direct it's maybe yeah maybe it's 1/5 of the time but um but

> there's a lot of times it's just it's making whatever we're doing uh more complex and usually take more time.

A healthcare manager participant shared his perceived patient care barrier based on social-economic status by explaining how patients end up seeking care from emergency department due to lack of access to clinical care.

> I think a lot of it is in that lower social and economic population because I don't think we as a health care system you know my system included do a good job of having availability for community clinic umm appointments. We have two providers in our community clinic for umm on average probably you know 60 to 70 patients a day just like primary care visits which are obviously pretty in depth and thorough and especially those patients that finally you know have lower socio-economic status have more comorbidities and so umm they simply don't have the support and time um and so I think then people fall through the cracks as well as they just simply can't see the patients after our emergency department visit for a long time so they just come back to us

Other categories include clinic role in improving patient healthcare outcomes and patient satisfaction with care as depicted in the triple aim framework. Participants shared their perception and experience with practice accessibility, current healthcare center improvements, and systemic and management issues. One patient participant shared her experience with improvement efforts her primary care clinic was doing. The participants shared that

> I think they strive to make it better 'cause I have been to one of their meetings where you know they want to know how we feel about certain situations and it's a nice meeting you meet with like the head doctor, the nurse coordinators, um you meet with a bunch of people that's important in their clinics to help things change so once they hear about 30 things that we you know suggest or maybe have influence in I think that they strive to make it better no matter what you know.

A provider participant expressed the importance of patient satisfaction and shared his experience with addressing what patient wants to see happen. “I think the system is sensitive to patient satisfaction and handles number one complaints really well and um put money into a new building that put everything together which makes it easier for patients to get around and do things, so I think they did some good they do do good things.”

Theme: Healthcare Payment System

The healthcare payment system theme was furthered categorized to cost of care, equity in patient care and payment system. Sub-categories of the payment system included cost reduction, reimbursement issues and insurance type. Insurance type captured participants type of insurance they have or accepted. This was important data to ensure that data was being collected from patients of low SES or PCPs and healthcare managers who provided care to patients from low SES backgrounds. All participants shared that they accept or were Medicaid and Medicare recipients.

Participants shared their thought on the healthcare payment system. Five participants shared their lived experience with reimbursement system in relations to visit duration and explained its impact on patient care:

> It is a reimbursement problem. like if you look at the, you know I don't only practice clinic I mean you know I have run dialysis units, I see people in hospital, I do procedures, you know my practice is I am a doctor and I got a lot of other stuff rolling out. And I got labs that I own. But if you were to look at the actual clinic day like the actual clinic day, I, we lose money every day that we are in clinic, we do not make money my practice is not. So, and that's probably it might be because we see people in 20 minutes instead of all of the other docs see in 10 to 15 minutes you know say it is certainly it's just a money losing option you don't need to not you can't you can't you're already losing money if you were to increase it to 30-40 minutes of time. And patient probably do need about 30 to 40 minutes yeah you would lose even further it's not it's not possible is it it's a Payor source issue it's really just that simple.

Equity in patient care captured participants’ responses in relation to payment system, insurance type, reimbursement, and patient care. Interview data showed connection between insurance type patients have and access to care. Patient participants shared their experience with accessing to care in the context of insurance types they have. Patient participant shared her experience with a healthcare facility while seeking care:

> Actually, that is just, because maybe it is good to go to a different hospital and some of them it is too expensive, you can’t afford. So, there will be like, you feel

> judgmental attitude at it, so maybe they will ask you just get the services from somewhere else, yeah, exactly. They feel if you can’t afford these there are other cheap places you can go to.

Another patient participant praised her primary care clinic for accepting patients without insurance. “well, I think they do pretty good because even if you don't have no insurance sometimes they still go ahead and see you, so.” A healthcare manager reported his clinic’s treatment of patients despite patient background:

> We treat all our patients the same so it doesn't matter like what their background is and um we believe that in order to our patients to ultimately have a healthy and active lifestyle that it starts with them coming to our office they're coming to our office we’re giving them a physical we’re looking at their overall you know overall picture if they need to lose weight the doctors are going to tell them you need to lose weight and that's not something you can bring up quickly like you have to you know those are sensitive matters too so we do believe for the over overall outcome of our patients it's important to be extremely thorough we do believe that.

Themes: Patient and Physician Satisfaction

Patient-physician satisfaction theme captured participants experience and perception of what leads to patient satisfaction with care and physician satisfaction with job. Participants identified access to care, listening, longer visit duration, and feeling welcomed to be essentials to patient satisfaction with care. Patient participant identified believing her and been heard to be an element of satisfaction with her PCP based on her experience.

> Because they sit there and listen to me and then they, it's like they feel that I that they feel that they know that I'm in pain, then you know that I, you know that I'm not lying and that's the that's the key thing there that I'm not lying and that I am telling this is not a thing that do this for another reason you know that's it that's what makes me trust.

Healthcare managers and PCP participants shared experiences with burnout and perceived burdens to PCP load. A PCP participant expressed his frustration with the system and stated that:

> We are being burdened to do more with less because frankly there aren't other services out there that should be doing it for them it's not people shouldn't be living in poverty in the United States and that is silly. But they sort of ask you like I should be sitting there like trying to I don't know it's just it's it's profoundly irritating is what I'm getting at.

Another provider participant explained provider burnout and his coping mechanism.

> So um secondary there's going to be a burnout factor if you're you're um you know highly loaded let's not say it overloaded but highly loaded all the time, you're more prone to burnout when you don't have enough when you don't have enough time in the visit to do everything and now you're resorting to other techniques whereas you you do uh quicker or face to face component you do your orders later like set how I said I love my orders in that half hour you know

> and I can talk with patient I'm doing the orders and talk about our plan 'cause that's where the orders that are, um so I think what you what you do in those cases you end up having more work after hours and at home a and you're going to risk the problems that come with that and that is less um satisfaction with your job then you might not perform as well you might not be as nice to patience um you know or you might be shorter with them because if they they do take up your time more than they need to.

Theme: Patient and Physician Relationship

Patients, PCP, and healthcare manager participants shared their views on components of the patient-physician relationship and PCP accessibility among other factors were discussed by participants in great length. A patient participant weighted on PCP accessibility and shared her experience with it.

> You find that some primary care providers are not all of that friendly, they don’t want to become accessible, and they are restricting, and you have to call direct the I don’t know the office, maybe it is an assistant that so that might create some barrier.

On the same note, another participant, but this time, a PCP conveys PCP accessibility to be an important aspect of good patient-physician relationship. The PCP participant shared that he gives his number to patients.

> I usually end up just giving them my direct extension so that they can leave me messages directly so that way at least know that if there is some kind of non-emergent issue that I can take care of it easily then I can just deal with it.”

Additionally, participants shared that communication, developing a repour, talking about patient families, length of the patient-physician relationship, PCP knowledge of the subject matter and skills, PCP personality, and trust are vital component of patient-physician relationship.

Theme: Patient Care

Participants shared their views and experiences on patient care. Seven participant responses were coded under attending to the patient. A patient participant shared her experience with her PCP who visited her after she delivered her child.

> You know like with me when I had my son she was she came to the hospital, you know, she talked to me about it she called me after hours just to check and see like if my blood pressure coming down you know but I could call you at your home I thought I was that mean that is on their mind and they really care so I feel like there my doctor really do care I think it's just the procedure within the clinic.

Similarly, a PCP participant shared his experience with patient care and type of care he provided to his patient:

> All the people had stayed got the care they needed 'cause I give everybody as much time as they need I don't I can't stick to the schedule because we're dealing with human beings who are biological systems with true sight psychosocial needs were all that way we all have 'em they vary from day to day to year to year to month to month and so so I gave everybody the time they need.

Theme: Patient Visit with PCP

Patient Visit with PCP theme emerged from information participants shared on their experiences and perception of the patient visit length with PCP, visit time sufficiency, experiences with waiting time, and visit content. Interview data showed that eight participants of the 15 participants expressed that the 15-20 minute visit duration created an environment where patient care was done in a rush. Twelve out of 15 participants shared that the average patient visit duration with their physician is 15-20 minutes and that this visit duration was not sufficient time to take care of patients in a holistic matter. Thirteen participants expressed wanting a longer visit spots or the existence of long visit duration at their clinics. Thirteen participants discussed their understanding and experience with visit time sufficiency.

Summary

The purpose of this qualitative exploratory multiple case study was to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the15-20 minute visit with PCPs in primary care clinics. The research question was: What are the common understandings from patients of lower socioeconomic backgrounds, healthcare providers, and healthcare administrative leaders of the 15-20 minute visit with PCPs in primary care clinics? After several cycles of coding, six main themes emerged from the interview data: healthcare management practices, healthcare payment system, patient and physician satisfaction, patient care, patient visit with PCPs, and patient-physician relationship. I asked interview questions aligned with the research questions, conceptual framework, problem statement, and past literature on this topic. Sections of

Chapter 4 included the research setting, demographics of the participants, data analysis, evidence of trustworthiness, the study result—the chapter summary. In Chapter 5, I will discuss the study results in greater detail and provide conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative exploratory multiple case study was to gain a shared understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the 15-20 minute visit with PCPs in primary care clinics. For this study, a qualitative research approach was chosen to explore how stakeholders of the 15-20 minute visits with PCPs have experienced this 15-20 minute visit duration. An exploratory multiple case study design was chosen for this study to gain an insight into the lived experience of patients, PCPs, and health care administrator leaders with the 15-20 minute visit policy with PCPs.

Fifteen participants were interviewed, five patients of low socioeconomic status, five PCPs, and five healthcare managers. The key findings from the data analysis of the participant interview showed that based on participants' experiences with the 15-20 minute visit duration with PCPs, it was not enough time to address healthcare and psychosocial concerns for most patients with lower socioeconomic status. Participants expressed several key issues that led to a short visit duration. Among them are healthcare management and payor issues. Participants discussed patient care in the context of short visit duration and shared the impact it has on how patients are treated, cared for, and access healthcare. Further, participants shared their lived experience with patient-physician relationship and satisfaction and expressed that, among other components, length of visit are a crucial component of satisfaction and good or bad relationship.

Interpretation of Findings

The study findings show that the standard 15-20 minute patient visit with PCPs is not enough time to provide holistic and high-quality care for patients with low socioeconomic status. Interview data showed that patients' perception and satisfaction with the visit duration were related to whether their questions and concerns were addressed and patients' relationship with PCPs. And for PCPs and healthcare managers, having enough face-to-face time with their patients was a crucial component of the job and visit satisfaction, among others. Interview data showed that patients, PCPs, and healthcare management participants shared their experience on the healthcare management and payment system's role in the 15-20 minute visit duration. The participants expressed that healthcare payment systems have an impact on the care patient receive and their perceptions of it.

The study results aligned with topics represented in the review of the literature section of this study. In the literature review chapter, I reviewed scholarly written work on themes such as patient visit duration with PCP, health disparities and the 15-minute visit duration, healthcare payment system, healthcare management practices, healthcare reimbursement system, and visit length and satisfaction. These themes also emerged in my collected interview data.

Patient Visit Duration with PCP

One of the interview questions directly addressed the 15-20 minute visit duration with PCP, and from participants' responses emerged the patient visit with PCP theme. Most participants expressed that the typical patient visit with PCP is about 15-20 minutes and that this visit duration was insufficient to provide holistic and high-quality care. This confirms prior research about the length of patient visits with medical providers showing that the average visit length is 15-20 minutes (Shaw et al., 2014; Stafford et al., 1999). Further, studies conducted by Migongo et al. (2012), Tai-Seale et al. (2007), and Young et al. (2018) suggested that the average patient visit length with a PCP is 15-20 minutes.

The interview data showed that patients' view of the visit duration sufficiency was based on several factors. First, patients evaluated their visit length with PCP based on addressing all patient questions, receiving a good workup lab to evaluate all presented symptoms, and not being rushed. Second, data interviews showed that the patient-PCP relationship and the length they have known each other contributes to visit length perception and satisfaction. Lastly, the ability of PCP to have control over their schedule and clinic flexibility contributed to short or extended visit duration.

The perception of the length of visit with PCP and what accounts are sufficient is crucial, particularly for patients and providers. Howe et al. (2019) evaluated the patient perception of visit length and its relationship to satisfaction with care and found that provider demeanors influenced patients' perception of visit length. Even though providers' visit with patients was 10 minutes long, patients who felt providers were warm, kind, attentive, caring, efficient, and knowledgeable perceived a more extended visit than the fixed 10 minutes.

My interview data results are consistent with Howe et al.’s (2019) findings. Participants, particularly patients' perception of the visit length, was related to their relationship and satisfaction with the PCP. When I asked participants to share the visit length with the PCP, most participants stated that it was 15-20 minutes. Few noted that it was longer than 20-minutes or as short as 10-minutes. Some participants felt that the current visit duration with PCP at their clinic was enough to receive holistic and good quality care, while others thought it was insufficient. Those who were indifferent about the length of the visit attributed to the visit content and their relationship with the provider. Patients who believed their questions were not addressed at the end of their visit thought that the visit length of 15-20 minutes was not adequate time for them to receive holistic and high-quality care. On the contrary, patient participants who reported that their visit length were sufficient time to receive good care, particularly those who stated that their visit durations were 15-20 minutes, reasoned that they were allowed to ask as many questions as possible and that their questions were addressed during the visit.

Visit content played an important role in how participants evaluated visit duration sufficiency. Patients, PCP, and healthcare managers shared that chronic and acute disease management, medication refills, discussions related to family and patients' children, preventative care discussions, labs, and psychosocial issues were contents of typical visits. PCP participant expressed that there was "a lot to cover in a short duration and little time to cover them all". Flocke et al.'s (2001) examination of the number of chief complaints patients presented during a typical visit with PCP showed that, on average, three problems were discussed during the visit. However, Flocke et al. noted that not all issues addressed during the visit were billed, thus, not accurately depicting PCP productivity. My study results go deeper into this issue. PCP participants shared that, on average, patients presented six points. Further, PCPs and healthcare managers expressed that complex patients needed more time to address health concerns and that visit duration should be 30-45 minutes.

Santo et al. (2019) research show that psychosocial issues are less likely to be discussed during a patient visit with PCPs. Santo et al. showed that providers dictated the content of the visit and prioritized addressing medically related concerns. On the other hand, patients' priorities were to discuss psychosocial issues. While the data interview in my study didn't explicitly show that PCPs favored addressing medical concerns over psychosocial issues, few PCPs explained that they get around the short visit duration by setting the visit agenda.

Patients, PCPs, and healthcare managers expressed the concept of rushed visits. Participants shared their experiences with visits they perceived were rushed and expressed that an extended visit of 30 minutes or more is a solution to rushed patient visits with PCP. This finding is aligned with Linzer et al. (2015) recommendation to increase routine visits with PCP to 30 minutes or more for patients with complex health care needs. PCP participants agreed with these recommendations, and one of the PCP participant mentioned that he strictly allow only nine patient visit slots a day to have about 30-45 minutes per patient.

Satisfaction and Visit Length

Patient Satisfaction.

The patient visit duration with PCP influences patient and physician satisfaction. Patient satisfaction with care is critical component of the triple aim framework. Previous literature on patient visit duration with PCP showed that patient perception of the visit length was related to satisfaction. The study conducted by Lin et al. (2001) highlighted the relationship between patient satisfaction and perceived visit length with PCP. The results showed that patients were satisfied when they predicted a short visit length but had a long visit and vice versa. Patients' perception of the visit length is linked to satisfaction. Similarly, my research data showed that patients who had a good relationship with their provider believed that the visit duration exceeded 15-20 minutes because the doctor was able to address the chief complaints patients brought to the visit even though the patient expressed uncertainty about the exact visit duration.

Patient participants shared their experiences with access to care and linked accessibility to satisfaction with care. One patient participant expressed that due to her low income, she believed that she didn't receive good quality care. Other patient participants conveyed a satisfactory experience with their PCPs, reasoning that their PCPs are accessible and can see them often. Previous research also showed that access to primary care is vital to patients and found that patients of low socioeconomic statutes preferred to use the emergency department for ambulatory care (Kangovi et al., 2013).

All participants shared that communication and listening to the patient are essential to patient satisfaction. PCP participants expressed that proper communication with patients and listening to them is critical to good quality care. The current visit duration doesn't allow room for that. However, most PCP participants shared that they still listen to their patients and communicate with them at the expense of staying late and doing progress notes and orders after work hours or at home.

Physician Satisfaction.

When it came to satisfaction with the visit duration with PCPs, most PCP participants expressed dissatisfaction with the 15-20 minute visit length, which is the stander for most primary care clinics. PCP participants conveyed unhappiness and frustration with the 15-20 minute visit duration. PCP participants explained that short visit duration with patients, burdens providers and leads to burnout resulting in job dissatisfaction. PCP and healthcare managers expressed that there is lack of discourse around the pressures PCPs deal with and the diversity of the patient panel.

The participants lived experience with the 15-20-minute visit duration confirms Linzer et al. (2000) argument that studies on visit duration have failed to depict the time pressure physicians experience when dealing with large patient panels. PCP participants explained that they are expected to do many things in such a short amount of time, including addressing visit concerns, doing wellness screening, orders, charting, talking to patients face-to-face, explaining and answering patients questions, and all while trying to provide holistic and high-quality care to patients. Further, PCP and healthcare management participants explained that the type of patients they see at their clinics are often patients of lower socioeconomic status with complex medical needs and some with language barriers.

The interview data can be compared to Varkey et al. (2009) findings that clinics that served minority patients were susceptible to significant challenges than those serving fewer minority patients due to existing barriers to accessing resources. Often, these clinics served patients with limited-English proficiency and psychosocial issues, which added to the complexity of their care. Further, Lichtenstein's (2016) examination of primary care visit length, content, and composition showed that medically complex and non-complex patients had the same visit duration. Thus, the author suggested that medically complex patients require adequate time to address all critical topics. Patients with complex health care needs need more time to address psychosocial and health concerns. These findings are supported by the interview data I collected from patients, PCPs, and healthcare managers.

Patient-Physician Relationship.

Patients, PCP, and healthcare manager participants shared their views on components of the patient-physician relationship. Participants reported that communication, developing a repour, talking about patient families, length of the patient-physician relationship, PCP knowledge of the subject matter and skills, PCP personality, and trust are all critical factors to a good or bad patient-physician relationship, among others.

Healthcare Payment System

Providers, healthcare leaders, and patients attributed short visit duration to several factors. PCP and healthcare manager participants blamed the healthcare payor system for being the driving force to the short visit duration. PCP and healthcare manager participants stated that due to low reimbursement issues from healthcare insurance providers, patient visit durations are shorter, and PCPs can not see patients for long visit duration. Further participants shared that healthcare payors continue to cut the cost of healthcare at the expense of patient care. PCP participants shared their experience with the reimbursements and conveyed that they are not adequately reimbursed for the care they provide to patients. PCP participants' claims confirm previous research on the healthcare payment system, which showed that the number of issues addressed during an office visit with family doctors was not reflective of the payments received for these services (Beasley et al., 2004).

Previous research on health disparities showed that patients of low socioeconomic status experience difficulties accessing healthcare (Kino & Kawachi, 2018). One research indicates that low-income patients preferred emergency department use due to a lack of access to primary care (Kangovi et al., 2013). Although data from patient participants' interviews didn't confirm the research findings of the two studies, patient participants discussed their experience with access to care related to their socioeconomic status. One of the patient participants shared the harsh treatment and judgmental attitude she experienced at a healthcare facility where she was discouraged from receiving healthcare. Other patient participants attributed good characteristics to their clinics and PCP because they were seen at these clinics despite their insurance type.

Limitations of the Study

Before collecting the data, I encountered limitations in finding clinics allowing me to collect data from patients, PCPs, and healthcare managers. Due to HIPPA privacy laws, healthcare facilities are rigorous on patient data. To overcome this hurdle, I stated in my request letter that I would not collect patient health data. Further, I did not ask physicians and healthcare leaders to discuss specifics about patient health or identifiable patient demographics. Also, I did not ask patients specifics about their health and kept questions specific to participants’ experience with the 15-20 minute visit duration with

PCPs. Participants were given informed consent, and I shared details of the research with all participants. Another limitation encountered is the source of data. The original plan was to collect data from three to five community clinics in Minnesota; however, due to COVID-19, clinics did not allow me to collect data at their facilities, which has led me to recruit participants from different places. Additionally, this study was limited to general primary care visits and did not evaluate visits where providers can bill for an extended visit length. The reason for this was that this study focused on exploring low SES patients, PCP, and healthcare leaders serving these patients' perception and experience with the 15-20 minutes visit duration.

Recommendations

The gap in the literature this study addressed was the possible impact of the 15-20 minute visit policy on patient health outcomes and satisfaction with care. Previous research on the patient visit duration did not explicitly show the perceived impact of short visit durations on patient satisfaction with care and patient health outcomes. This study confirms some of the previous work on patient perception of visit duration and satisfaction. Patients reported that visit duration was not adequate time to receive the care they needed when they felt like their questions were not addressed despite visit length. On the other hand, patients with good relationships and experience with their PCPs did not care much about the visit length and thought their current visit duration was sufficient to receive good care. Thus, there is a need to explore patients' perception of visit duration and their health outcomes. Further, there is a need for future studies that quantifies the exact time patients spend with PCP face-to-face, specifically patients of low socioeconomic status linking that to types of patient visits and patient satisfaction with care.

Implications

Significance to Social Change

The research findings from this study might have potential benefits to economically disadvantaged populations. Lower socioeconomic status is linked to lower health status (Kawachi & Kennedy, 1997). Daepp and Arcaya (2017) examined the effect of health on socioeconomic status, looking at diabetes patients. While the results did not show that higher hemoglobin A1c, a measure of the blood glucose levels in the past three months, did not lead to lower socioeconomic status, the authors found that those with low socioeconomic status had higher hemoglobin A1c. The 15-20 minute visit policy with PCPs hinders the delivery of comprehensive and quality care to patients of low socioeconomic status. According to Linzer et al. (2015), doctors are expected to see as many patients as possible each day to cover the overhead cost; thus, they are limited to a visit length of 15-20 minutes. The results of this study might help healthcare leaders address improving access and quality of care for economically disadvantaged patients by creating patient visit policy that is longer than the 15-20 minutes and reflective of individual patient needs.

Significance to Theory

Economically disadvantaged patients often experience low access to care (Kirby, 2008). Many researchers in the field of access to care, primary care visit duration, and health quality improvement have focused on patients with chronic conditions and overall access to care. In this research, I specifically explored the 15-20 minute visit with primary care's effectiveness in caring for patients from low socioeconomic backgrounds. The existing literature on the 15-20 minute visit with PCPs has not focused enough on exploring the effectiveness of this visit duration on patients of low socioeconomic status. The research finding from this study might offer insights into incorporating extended patient visit policy into the triple aim framework that is reflective of individual patient needs.

Significance to Practice

The result of this study might be useful to patients of low socioeconomic status, PCPs, and healthcare administrative leaders serving patients of low socioeconomic background in evaluating the 15-20 minute visit policy with PCPs. In particular, the study helped answer the question: Is the 15-20 minute visit with PCPs appropriate for patients of low socioeconomic status? Patients receiving care in inner-city clinics have shorter visit duration than those receiving care in salaried group practices in academic centers (AMC) or at managed care group (MCG) clinics (Tai-Seale et al., 2007). The results of the study might help patients gain a perspective on the effects of the 15-20 minute visit duration with PCPs on patient care. Further, healthcare providers of low socioeconomic background patients could better understand the common understanding patients and healthcare administrative have on the 15-20 minute visit policy. The study could help healthcare administrator leaders at healthcare clinics serving low-income patients to strategize more effective visit policies for populations they serve by increasing visit duration to address psychosocial issues.

Conclusions

The study's overall findings showed that based on the lived experience of the three stakeholders of the 15-20 minute visit duration with PCP, this visit duration is not sufficient for holistic patient care for low-income patients with psychosocial issues. Several themes emerged from participant interviews dealing with participants' perceptions of visit duration, the healthcare payor and management system, patient-physician relationship and satisfaction, and patient care in primary care settings. In the literature review chapter, I reviewed scholarly written work on themes such as patient visit duration with PCP, health disparities and the 15-minute visit duration, healthcare payment system, healthcare management practices, healthcare reimbursement system, and visit length and satisfaction. Those themes reappeared in my collected interview data. The study results were mainly aligned with topics depicted in the literature review. The patient visit duration with PCP is insufficient to provide quality care for all patient types, particularly those with low SES. Data interview from my study showed that patients, PCPs, and healthcare managers valued longer face-to-face time during the visit.

References

Abbo, E. D., Zhang, Q., Zelder, M., & Huang, E. S. (2008). The increasing number of clinical items addressed during the time of adult primary care visits. *Journal of General Internal Medicine*, *23*(12), 2058.

Adler-Milstein, J., & Huckman, R. S. (2013). The Impact of Electronic Health Record Use on Physician Productivity. *American Journal of Managed Care*, 19, SP345–52.

Adler, N. E., & Snibbe, A. C. (2003). The role of psychosocial processes in explaining the gradient between socioeconomic status and health. *Current Directions in Psychological Science, 12*(4), 119-123. doi:10.1111/1467-8721.01245

Alarcon-Ruiz, C. A., Heredia, P., & Taype-Rondan, A. (2019). Association of waiting and consultation time with patient satisfaction: secondary-data analysis of a national survey in Peruvian ambulatory care facilities. *BMC Health Services Research, 19*(1), 439. doi:10.1186/s12913-019-4288-6

Anderson, R. T., Camacho, F. T., & Balkrishnan, R. (2007). Willing to wait? The influence of patient wait time on satisfaction with primary care. *BMC Health Services Research*, *7*(1), 31. doi:10.1186/1472-6963-7-31

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. CMAJ: Canadian Medical Association Journal = *Journal De L'association Medicale Canadienne*, *188*(17–18), E474–E483. doi:10.1503/cmaj.160177

Arpey, N. C., Gaglioti, A. H., & Rosenbaum, M. E. (2017). How socioeconomic status affects patient perceptions of health care: a qualitative study. *Journal of Primary Care & Community Health*, *8*(3), 169-175. doi:10.1177/2150131917697439

Ash, A. S., Mick, E. O., Ellis, R. P., Kiefe, C. I., Allison, J. J., & Clark, M. A. (2017). Social Determinants of Health in Managed Care Payment Formulas. *JAMA Internal Medicine*, 177(10), 1424–1430. doi:10.1001/jamainternmed.2017.3317

Aspers, P., & Corte, U. (2019). What is qualitative in qualitative research. *Qualitative Sociology*, *42*(2), 139-160. doi:10.1007/s11133-019-9413-7

Babbie, E. (2017). *Basics of social research (7th ed.)*. Boston, MA: Cengage Learning.

Barksdale Jr, H. C., Johnson, J. T., & Suh, M. (1997). A relationship maintenance model: A comparison between managed health care and traditional fee-for-service. *Journal of Business Research*, *40*(3), 237-247. doi: 10.1016/S0148-2963(96)00240-8

Baron, M. A. (2008). Guidelines for writing research proposals and dissertations. Division of Educational Administration: University of South Dakota, 1-52.

Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report*, *13*(4), 544-559. https://nsuworks.nova.edu/tqr/vol13/iss4/2

Beasley, J. W., Hankey, T. H., Erickson, R., Stange, K. C., Mundt, M., Elliott, M., & Bobula, J. (2004). How many problems do family physicians manage at each encounter? A WReN study. *The Annals of Family Medicine*, *2*(5), 405-410. doi: 10.1370/afm.94

Becker, G., & Newsom, E. (2003). Socioeconomic status and dissatisfaction with health care among chronically ill African Americans. *American Journal of Public Health*, *93*(5), 742-748. doi:10.2105/AJPH.93.5.742

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, *27*(3), 759–69.doi:10.1377/hlthaff.27.3.759

Blumenthal, D., Causino, N., Chang, Y., Culpepper, L., Marder, W., Saglam, D., & Starfield, B. (1999). The duration of ambulatory visits to physicians. *Journal of Family Practice*, *48*(4), 264-272. Retrieved from https://www.mdedge.com/familymedicine

Blanco, I., Barjaktarovic, N., & Gonzalez, C. M. (2020). Addressing health disparities in medical education and clinical practice. *Rheumatic Disease Clinics*, *46*(1), 179-191. doi:10.1016/jrdc.2019.09.012

Britton, J. R. (2015). Healthcare reimbursement and quality improvement: Integration using the electronic medical record: Comment on" fee-for-service payment-an evil practice that must be stamped out?". *International journal of health policy and management*, *4*(8), 549. doi: 10.15171/ijhpm.2015.93

Burkholder, G. J., Cox, K., & Crawford, L. (2016). *The Scholar-Practitioner's Guide to Research Design*. Laureate Publishing, 2016-02-01. VitalBook

Burgess, D. J. (2010). Are providers more likely to contribute to healthcare disparities under high levels of cognitive load? How features of the healthcare setting may lead to biases in medical decision making. *Medical Decision Making*, *30*(2), 246–257. doi:10.1177/0272989X09341751

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *The Annals of Family Medicine, 12*(6), 573-576. doi:10.1370/afm.1713

Bolen, S. D., Sage, P., Perzynski, A. T., & Stange, K. C. (2016). No moment wasted: The primary-care visit for adults with diabetes and low socio-economic status. *Primary Health Care Research & Development*, 17(1), 18-32. doi: 10.1017/S1463423615000134

Braddock, C. H., & Snyder, L. (2005). The doctor will see you shortly. *Journal of general internal medicine*, *20*(11), 1057-1062. doi: 10.1111/j.1525-1497.2005.0217.x

Cassell, C., Cunliffe, A. L., & Grandy, G. (2018). *The Sage handbook of qualitative business and management research methods*. Sage. doi: 10.4135/9781526430212

Castillo-Montoya, M. (2016). Preparing for interview research: The interview protocol refinement framework. *The Qualitative Report*, *21*(5), 811-831. Retrieved from https://nsuworks.nova.edu/tqr/

Chen, L. M., Farwell, W. R., & Jha, A. K. (2009). Primary care visit duration and quality: does good care take longer?. *Archives of internal medicine*, 169(20), 1866-1872. doi:10.1001/archinternmed.2009.341

Chen, E., Martin, A. D., & Matthews, K. A. (2006). Socioeconomic status and health: Do gradients differ within childhood and adolescence? *Social Science & Medicine, 62*(9), 2161-2170. doi:10.1016/j.socscimed.2005.08.054

Clark, V. L. P., & Creswell, J. W. (2015). Understanding research: A consumer's guide.

Pearson Higher Ed.

Crabtree, B. F., & Miller, W. L. (1999). *Doing qualitative research*. Thousand Oaks, CA Sage

Creswell, J. W. & Creswell J.D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Thousand Oaks, CA: Sage.

Daepp, M. I., & Arcaya, M. C. (2017). The effect of health on socioeconomic status: Using instrumental variables to revisit a successful randomized controlled trial. *Economics & Human Biology*, *27*, 305-314. doi:10.1016/j.ehb.2017.09.002

Denzin, N., & Lincoln, Y. (Eds.). (2005). *Handbook of qualitative research (3rd ed.)*. Thousand Oaks, CA: Sage.

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, *13*(3), 7-21. doi:10.7748/nr2006.04.13.3.7.c5975

Dugdale, D. C., Epstein, R., & Pantilat, S. Z. (1999). Time and the patient–physician relationship. *Journal of General Internal Medicine, 14*(S1), 34-40.

Ellis, T. J., & Levy, Y. (2009). Towards a Guide for Novice Researchers on Research Methodology: Review and Proposed Methods. *Issues in Informing Science & Information Technology*, *6*.

Eriksson, P. & Kovalainen, A. (2008). Research design and process. In Eriksson, P., & Kovalainen, A. *Introducing Qualitative Methods: Qualitative methods in business research* (pp. 25-36). London: SAGE Publications Ltd doi: 10.4135/9780857028044

Feddock, C. A., Hoellein, A. R., Griffith, C. H., Wilson, J. F., Bowerman, J. L., Becker, N. S., & Caudill, T. S. (2005). Can physicians improve patient satisfaction with long waiting times? *Evaluation & the Health Professions, 28*(1), 40-52. doi:10.1177/0163278704273084

Feltner, F., Thompson, S., Baker, W., & Slone, M. (2017). Community health workers improving diabetes outcomes in a rural Appalachian population. *Social Work in Health Care, 56*(2), 115–123. doi:10.1080/0098

Fiscella, K., & Epstein, R. M. (2008). So much to do, so little time: Care for the socially disadvantaged and the 15-minute visit. *Archives of Internal Medicine*, *168*(17), 1843-1852. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2606692/

Flocke, S. A., Frank, S. H., & Wenger, D. A. (2001). Addressing multiple problems in the family practice office visit. *Journal of Family Practice*, *50*(3), 211-211. https://www.mdedge.com/familymedicine

Geraghty, E. M., Franks, P., & Kravitz, R. L. (2007). Primary care visit length, quality, and satisfaction for standardized patients with depression. *Journal of general internal medicine*, *22*(12), 1641-1647.. doi:10.1007/s11606-007-0371-5

Getzen, T. (2015). *Health economics for the healthcare administrator* (Laureate custom edition). New York: Wiley.

Given, L. M. (2008). The Sage encyclopedia of qualitative research methods (Vols. 1-0). Thousand Oaks, CA: Sage. doi:10.4135/9781412963909

Gottschalk, A., & Flocke, S. A. (2005). Time spent in face-to-face patient care and work outside the examination room. *The Annals of Family Medicine, 3*(6), 488-493. https://www.mdedge.com/familymedicine

Gross, D. A., Zyzanski, S. J., Borawski, E. A., Cebul, R. D., & Stange, K. C. (1998). Patient satisfaction with time spent with their physician. *Journal of Family Practice*, 47(2), 133-138. Retrieved from https://www.mdedge.com/familymedicine

Guest, G., Namey, E., & Mitchell, M. (2013). Qualitative research: Defining and designing. In G. Guest, E. Namey, & M. Mitchell (Eds.) *Collecting qualitative data: A field manual for applied research* (pp. 1-40). London, UK: Sage.

Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: when to use them and how to judge them. *Human Reproduction, 31*(3), 498-501. doi:10.1093/humrep/dev334

Hariri, S., Bozic, K. J., Lavernia, C., Prestipino, A., & Rubash, H. E. (2007). Medicare physician reimbursement: past, present, and future. *The Journal of Bone & Joint Surgery*, *89*(11), 2536-2546. doi:10.2106/JBJS.F.00697

Heisler, M., DeMonner, S. M., Bili, J. E., & Hayward, R. A. (2003). Medicaid managed care: Are academic medical centers penalized by attracting patients with high-cost conditions? *American Journal of Managed Care*, *9*(1), 19-32.

Hill, N. T. (2000). Adoption of costing systems in US hospitals: An event history analysis 1980–1990. *Journal of Accounting and Public Policy, 19*(1), 41–71. doi:10.1016/S0278-4254(99)00013-7

Hooker, C. (2010). History and social change in health and medicine. In I. Bourgeault, R. Dingwall, & R. de Vries (Eds.) *The Sage handbook of qualitative methods in health research* (pp. 265-286). London, UK: Sage. doi:10.4135/9781446268247

Howe, L. C., Hardebeck, E. J., Leibowitz, K. A., & Crum, A. J. (2019). Providers' demeanor impacts patient perceptions of visit length. *Journal of general internal medicine*, *34*(2),82-183. doi:10.1007/s11606-018-4665-6

Institute for Healthcare Improvement (IHI). 2020. "IHI Triple Aim Initiative." http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Katon, W. J., & Unützer, J. (2013). Health reform and the Affordable Care Act: the importance of mental health treatment to achieving the triple aim. *Journal of Psychosomatic Research, 74*(6), 533-537. doi:10.1016/j.jpsychores.2013.04.005.

Kawachi, I., & Kennedy, B. P. (1997). Socioeconomic determinants of health: Health and social cohesion: Why care about income inequality? *BMJ: British Medical Journal*, *314*(7086), 1037. doi:10.1136/bmj.314.7086.1037

Kangovi, S., Barg, F. K., Carter, T., Long, J. A., Shannon, R., & Grande, D. (2013). Understanding why patients of low socioeconomic status prefer hospitals over ambulatory care. *Health Affairs*, *32*(7), 1196-1203. doi:10.1377/hlthaff.2012.0825

Kino, S., & Kawachi, I. (2018). The impact of ACA Medicaid expansion on socioeconomic inequality in health care services utilization. *PLoS ONE*, *12*, e0209935. doi:10.1371/journal.pone.0209935

Kirby, J. B. (2008). Poor people, poor places and access to health care in the United States. *Social Forces*, *87*(1), 325–355. doi:10.1353/sof.0.0062

Klitzman, R. (2007). “Patient-time”, “doctor-time”, and “institution-time”: Perceptions and definitions of time among doctors who become patients. *Patient Education and Counseling*, *66*(2), 147-155. doi:10.1016/j.pec.2006.10.005

Konrad, T. R., Link, C. L., Shackelton, R. J., Marceau, L. D., von dem Knesebeck, O., Siegrist, J., & McKinlay, J. B. (2010). It's about time: Physicians' perceptions of time constraints in primary care medical practice in three national healthcare systems. *Medical care, 48*(2), 95–100. doi:10.1097/MLR.0b013e3181c12e6a

Lichtenstein, M. R. (2016). *The Association Between Patient Complexity and Primary Care Visit Length and Composition* (Doctoral dissertation, Harvard University). http://nrs.harvard.edu/urn-3:HUL.lnstRepos:27007752

Lin, C. T., Albertson, G. A., Schilling, L. M., Cyran, E. M., Anderson, S. N., Ware, L., & Anderson, R. J. (2001). Is patients' perception of time spent with the physician a determinant of ambulatory patient satisfaction? *Archives of Internal Medicine*, *161*(11), 1437-1442.

Linzer, M., Bitton, A., Tu, S., Plews-Ogan, M., Horowitz, K. R., Schwartz, M. D., & Fairfield, K. (2015). The End of the 15-20-minute primary care visit. *Journal of General Internal Medicine*, *30*(11), 1584-1586. doi:10.1007/s11606-015-3341-3

Linzer, M., Bitton, A., Tu, S., Plews-Ogan, M., Horowitz, K. R., Schwartz, M. D., & Rhodes, E. (2000). Managed care, time pressure, and physician job satisfaction: Results from the physician work life study. *Journal of General Internal Medicine*, 15(7), 441-450. https://www.springer.com/journal/11606?gclid=Cj0KCQjws_r0BRCwARIsAMxf

DRiqecyPXIYEZmQB2zA_m6i_PtTXmGe_o7paCKPw5MSNu2xtdbLRhyQaAlXmEALw_wcB

Liu, L., Gauri, D. K., & Jindal, R. P. (2021). The Role of Patient Satisfaction in Hospitals' Medicare Reimbursements. *Journal of Public Policy & Marketing*, 40(4), 558–570. doi:10.1177/0743915620984723

Lorenzetti, R. C., Jacques, C. M., Donovan, C., Cottrell, S., & Buck, J. (2013). Managing difficult encounters: Understanding physician, patient, and situational factors. *American Family Physician*, *87*(6), 419-425. https://www.aafp.org/journals/afp.html

Lowe, R. A., Localio, A. R., Schwarz, D. F., Williams, S., Tuton, L. W., Maroney, S., Nicklin, D., Goldfarb, N., Vojta, D. D., & Feldman, H. I. (2005). Association between Primary Care Practice Characteristics and Emergency Department Use in a Medicaid Managed Care Organization. *Medical Care*, *43*(8), 792–800. http://www.jstor.org/stable/3768297

Maniam, G. (2018). Effect of managed care systems on healthcare quality of low-income women. *Journal of Business & Educational Leadership*, *7*(1), 72–85. http://asbbs.org/files/2018/JBEL7.1.pdf#page=72

Marshall, C., & Rossman, G. B. (1995). *Designing qualitative research*. Thousand Oaks, CA: Sage.

Maxwell, J. A. (2009). Designing a qualitative study. In Bickman, L., & Rog, D. J. *The SAGE handbook of applied social research methods* (pp. 214-253). Thousand Oaks, CA: Sage. doi: 10.4135/9781483348858

McCabe, J. L., & Holmes, D. (2009). Reflexivity, critical qualitative research and emancipation: A Foucauldian perspective. *Journal of Advanced Nursing* 65(7), 1518–1526. doi:10.1111/j.1365-2648.2009.04978.x

McCarthy, D., & Klein, S. (2010). The triple aim journey: Improving population health and patients' experience of care, while reducing costs. https://www.commonwealthfund.org

McClellan, M. (2011). Reforming payments to healthcare providers: The key to slowing healthcare cost growth while improving quality?. *Journal of Economic Perspectives*, *25*(2), 69-92.doi=10.1257/jep.25.2.69

Mechanic, D., McAlpine, D. D., & Rosenthal, M. (2001). Are patients' office visits with physicians getting shorter? *New England Journal of Medicine*, *344*(3), 198-204. doi:10.1056/nejm200101183440307

Meijer, P. C., Verloop, N., & Beijaard, D. (2002). Multi-method triangulation in a qualitative study on teachers' practical knowledge: An attempt to increase internal validity. *Quality and Quantity*, *36*(2), 145-167. doi: 10.1023/A:1014984232147

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.

Migongo, A. W., Charnigo, R., Love, M. M., Kryscio, R., Fleming, S. T., & Pearce, K. A. (2012). Factors relating to patient visit time with a physician. *Medical Decision Making*, *32*(1), 93-104. doi: 10.1177/0272989X10394462

Moseley III, G. B. (2008). The US health care non-system, 1908-2008. *AMA Journal of Ethics*, *10*(5), 324-331.doi: 10.1001/virtualmentor.2008.10.5.mhst1-0805.

Nembhard, I. M., Yuan, C. T., Shabanova, V., & Cleary, P. D. (2015). The relationship between voice climate and patients' experience of timely care in primary care clinics. *Health Care Management Review*, *40*(2), 104.

Norlyk, A., & Harder, I. (2010). What makes a phenomenological study phenomenological? An analysis of peer-reviewed empirical nursing studies. *Qualitative Health Research*, *20*(3), 420-431.DOI: 10.1177/1049732309357435

Obucina, M., Harris, N., Fitzgerald, J. A., Chai, A., Radford, K., Ross, A., & Vecchio, N. (2018). The application of triple aim framework in the context of primary healthcare: A systematic literature review. *Health Policy*, *122*(8), 900-907. doi:10.1016/j.healthpol.2018.06.006

O'Malley, A. S., Rich, E. C., Shang, L., Rose, T., Ghosh, A., Poznyak, D., & Peikes, D. (2019). New approaches to measuring the comprehensiveness of primary care physicians. *Health Services Research*, *54*(2), 356-366. doi: 10.1111/1475-6773.13101

Oversveen, E., Rydland, H. T., Bambra, C., & Eikemo, T. A. (2017). Rethinking the relationship between socio-economic status and health: Making the case for sociological theory in health inequality research. *Scandinavian Journal of Public Health*, *45*(2), 103–112. doi:10.1177/1403494816686711

Pathak, V., Jena, B., & Kalra, S. (2013). Qualitative research. *Perspectives in Clinical Research*, *4*(3).192. doi:10.4103/2229-3485.115389

Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: Theory, evidence, and policy implications. *Journal of Health and Social Behavior*, *51*(1_suppl), S28–S40.doi:10.1177/0022146510383498

Poulton, R., Caspi, A., Milne, B. J., Thomson, W. M., Taylor, A., Sears, M. R., & Moffitt, T. E. (2002). Association between children's experience of socioeconomic disadvantage and adult health: a life-course study. *The lancet*, *360*(9346), 1640-1645. doi: 10.1016/S0140-6736(02)11602-3

Privett, N., & Guerrier, S. (2021). Estimation of the time needed to deliver the 2020 USPSTF preventive care recommendations in primary care. *American journal of public health*, 111(1), 145-149. doi:10.2105/AJPH.2020.305967

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Thousand Oaks, CA: Sage.

Reiter, K. L., Halladay, J. R., Mitchell, C. M., Ward, K., Lee, S.-Y. D., Steiner, B., & Donahue, K. E. (2014). Costs and benefits of transforming primary care practices: A qualitative study of North Carolina’s improving performance in practice. *Journal of Healthcare Management / American College of Healthcare Executives*, *59*(2), 95–108. https://journals.lww.com/jhmonline/pages/default.aspx

Riste, L. K., Coventry, P. A., Reilly, S. T., Bower, P., & Sanders, C. (2018). Enacting person-centredness in integrated care: A qualitative study of practice and perspectives within multidisciplinary groups in the care of older people. *Health Expectations*, *21*(6), 1066–1074. doi:10.1111/hex.12803

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data*. (3rd ed.). Thousand Oaks, CA: Sage.

Saldana, J. (2009). *The coding manual for qualitative researchers*. (3rd ed.). Thousand Oaks, CA: Sage

Santo, E. C., Vo, M. T., Uratsu, C. S., & Grant, R. W. (2019). Patient-defined visit priorities in primary care: Psychosocial versus medically related concerns. *Journal of The American Board of Family Medicine, 32*(4), 513–520. doi:10.3122/jabfm.2019.04.180380

Schneider, A. (1997). Overview of Medicaid provisions in the Balanced Budget Act of 1997, P.L. 105-33. *Center on Budget and Policy Priorities*. Retrieved from: https://www.cbpp.org *Revised, September 8, 1997*

Scholle, S. H., Mardon, R., Shih, S. C., & Pawlson, L. G. (2005). Trends from the field. The relationship between quality and utilization in managed care. *American Journal of Managed Care*, *11*(8), 521–527. https://www.ajmc.com

Setia, M. S. (2017). Methodology series module 10: Qualitative health research. *Indian Journal of Dermatology, 62*(4), 367–370. doi:10.4103/ijd.IJD_290_17

Shim, R., & Rust, G. (2013). Primary care, behavioral health, and public health: Partners in reducing mental health stigma. *American Journal of Public Health, 103*(5), 774-776. doi:10.2105/AJPH.2013.301214

Shaw, M. K., Davis, S. A., Fleischer, A. B., & Feldman, S. R. (2014). The duration of office visits in the United States, 1993 to 2010. *American Journal of Managed Care*, *20*(10), 820-826. Retrieved from https://www.ajmc.com

Shi, L., & Singh, D. (2015). *Delivering health care in America: A systems approach* (6th ed.). Burlington, MA: Jones & Bartlett.

Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., & Blike, G. (2016). Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Annals of Internal Medicine*, *165*(11), 753–760. doi:10.7326/M16-0961

Smith, J., & Firth, J. (2011). Qualitative data analysis: The framework approach. *Nurse Researcher, 18*(2), 52-62. http://dx.doi.org/10.7748/nr2011.01.18.2.52.c8284

Smith, P. R. (2018). Collecting Sufficient Evidence When Conducting a Case Study. The Qualitative Report, 23(5), 1054-1048. https://nsuworks.nova.edu/tqr/vol23/iss5/2

Sodhi, N., Piuzzi, N. S., Khlopas, A., Newman, J. M., Kryzak, T. J., Stearns, K. L., & Mont, M. A. (2018). Are we appropriately compensated by relative value units for primary vs revision total hip arthroplasty?. *The Journal of Arthroplasty*, *33*(2), 340-344. doi:10.1016/j.arth.2017.09.019

Sodhi, N., Piuzzi, N. S., Khlopas, A., Newman, J. M., Kryzak, T. J., Stearns, K. L., & Solomon, J. (2008). How strategies for managing patient visit time affect physician job satisfaction: A qualitative analysis. *Journal of General Internal Medicine*, *23*(6), 775-780. doi:10.1007/s11606-008-0596-y

Solomon, J. (2008). How strategies for managing patient visit time affect physician job satisfaction: a qualitative analysis. *Journal of General Internal Medicine*, 23(6), 775-780. doi:10.1007/s11606-008-0596-y

Sommers, B. D., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2016). Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. *JAMA Intern Medicine, 176*(10):1501–1509. doi:10.1001/jamainternmed.2016.4419

Sommers, B. D., Gawande, A. A., & Baicker, K. (2017). Health insurance coverage and health: What the recent evidence tells us. *The New England Journal of Medicine, 56*, 586-593. doi:10.1056/NEJMsb1706645

Stafford, R. S., Saglam, D., Causino, N., Starfield, B., Culpepper, L., Marder, W. D., & Blumenthal, D. (1999). Trends in adult visits to primary care physicians in the United States. *Archives of Family Medicine, 8*(1), 26-32.

Stiefel, M., & Nolan, K. (2013). Measuring the triple aim: A call for action. *Population Health Management, 16*(4), 219-220. doi.10.1089/pop.2013.0025

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy, 68*(3), 226-231. doi:10.4212/cjhp.v68i3.1456

Tai-Seale, M., McGuire, T. G., & Zhang, W. (2007). Time allocation in primary care office Visits. *Health Services Research, 42*(5), 1871–1894. doi:10.1111/j.1475-6773.2006.00689.x

Tai-Seale, M., Olson, C. W., Li, J., Chan, A. S., Morikawa, C., Durbin, M., & Luft, H. S. (2017). Electronic health record logs indicate that physicians split time evenly between seeing patients and desktop medicine. *Health Affairs, 36*(4), 655-662. doi:10.1377/hlthaff.2016.0811

U.S. Department of Health and Human Services. Draft report of the Secretary's advisory committee on national health promotion and disease prevention objectives for 2020 on social determinants; revised 2009 Sep 9. https://www.healthypeople.gov/2020/about/foundation-health-measures/Determinants-of-Health

Varkey, A. B., Manwell, L. B., Williams, E. S., Ibrahim, S. A., Brown, R. L., Bobula, J. A., & Linzer, M. (2009). Separate and unequal: Clinics where minority and nonminority patients receive primary care. *Archives of Internal Medicine, 169*(3), 243-250. doi:10.1001/archinternmed.2008.559

Venkataramani A, Daza S, Emanuel E. Association of Social mobility with the income-related longevity gap in the United States: A cross-sectional, county-lLevel study. *Journal of the American Medical Association Internal Medicine*. Published online January 21, 2020. doi:10.1001/jamainternmed.2019.6532

Wang, C. J., Conroy, K. N., & Zuckerman, B. (2009). Payment reform for safety-net institutions—improving quality and outcomes. *New England Journal of Medicine, 361*(19), 1821-1823. doi:10.1056/NEJMp0907656

Weiss, D., & Eikemo, T. A. (2017). Technological innovations and the rise of social inequalities in health. *Scandinavian Journal of Public Health, 45*(7), 714–719. doi:10.1177/14034948177111371

West, C. P. (2016). Physician well-being: Expanding the triple aim. *Journal of General Internal Medicine, 31*(5), 458-459. doi:10.1007/s11606-016-3641-2

Wilson, A., & Childs, S. (2002). The relationship between consultation length, process and outcomes in general practice: A systematic review. *British Journal of General Practice*, *52*(485), 1012-1020. Retrieved from https://bjgp.org

Wheat, H., Horrell, J., Valderas, J. M., Close, J., Fosh, B., & Lloyd, H. (2018). Can practitioners use patient reported measures to enhance person centred coordinated care in practice? A qualitative study. *Health and Quality of Life Outcomes*, *16*(1), 223. doi:10.1186/s12955-018-1045-1

Whittington, J. W., Nolan, K., Lewis, N., & Torres S, T. (2015). Pursuing the triple aim: The first 7 years. *Milbank Quarterly*, *93*(2), 263–300. doi:10.1111/1468-0009.

Yahya, S., & Goh, W. (2002). Managing human resources toward achieving knowledge management. *Journal of Knowledge Management*, 6(5), pp. 457–468. doi: 10.1108/13673270210450414.

Yarnall, K. S. H., Pollak, K. I., Ostbye, T., Krause, K. M., & Michener, J. L. (2003). Primary care: Is there enough time for prevention? *American Journal of Public Health*, *93*(4), 635–641. doi:10.2105/AJPH.93.4.635

Yilmaz, K. (2013). Comparison of quantitative and Qualitative research traditions: Epistemological, theoretical, and methodological differences. *European Journal of Education*, *48*(2), 311-325. doi:10.1111/ejed.12014

Yin, R. K. (2018). *Case study research and applications: Design and methods*. (6th ed.). Los Angeles, CA: Sage.

Yiu, A. T. (2004). The effects of HMOs on the length of physician-patient visit. *Conference Papers -American Sociological Association*, 1–22. https://www.asanet.org

Young, R. A., Burge, S. K., Kumar, K. A., Wilson, J. M., & Ortiz, D. F. (2018). A time-motion study of primary care physicians' work in the electronic health record era. *Family Medicine, 50*(2), 91-99. doi:10.22454/FamMed.2018.184803.

Zallman, L., Finnegan, K., Roll, D., Todaro, M., Oneiz, R., & Sayah, A. (2018). Impact of medical scribes in primary care on productivity, face-to-face time, and patient comfort. *The Journal of the American Board of Family Medicine*, *31*(4), 612-619. doi:10.3122/jabfm.2018.04.170325

Zelman, W. N., McCue, M. J., Glick, N. D., & Thomas, M. S. (2014). *Financial management of health care organizations: an introduction to fundamental tools, concepts, and applications*. San Francisco, CA: Jossey-Bass.

Zhang, C.-Q., Chung, P-K., Zhang, R. & Schüz, B. (2019). Socioeconomic inequalities in older adults' health: The roles of neighborhood and individual-level psychosocial and behavioral resources. *Frontiers in Public Health*. doi:10.3389/fpubh.2019.00318

Zyzanski, S. J., Stange, K. C., Langa, D., & Flocke, S. A. (1998). Trade-offs in high-volume primary care practice. *Journal of Family Practice, 46*(5), 397-403.

Appendix A: Interview Protocol Appendix

Date:

Start time:

Stop time:

Total Time:

Participant ID #:

[*Interview session starts*]

Hello, and I want to thank you again for accepting to participate in my study. My name is Zuhur Ahmed. I am a Ph.D. candidate at Walden University, studying management with an emphasis on leadership and organizational change. The purpose of this qualitative exploratory multiple case study is to gain common understanding from patients with low socioeconomic status, healthcare providers, and healthcare administrative leaders of low socioeconomic background about the15-to 20-minute visit with PCP in primary care clinics. The purpose of the interview is to help me explore how different stakeholders of the 15-to 20-minute visit duration with primary care providers (PCPs) have experienced this phenomenon.

The interview questions are open-ended. I want to request your permission by signing the consent form indicating that I have your permission to audio record our conversation. Along with audio recording our conversation, during the interview, I might take notes to ensure that I accurately capture your statements. Again, I want to assure you that your identity will not be revealed. You have the choice to end the interview at any time. If you do end the interview, no answers you provided to that point will be used and I will delete the recording right there. This interview will take approximately one hour.

Before we get started, are there any questions or concerns? If any questions arise at any point during the interview, feel free to ask them at any time and I would be more than happy to address all your questions and concerns.

Interview Procedures

To facilitate my notetaking, I would like to audio-record the interview. I am requesting that you permit me to conduct an audio-recorded interview by signing the release from. I will be the only one who will be privy to the recordings. I have planned this interview to last no longer than 60 minutes. Transcriptions of interviews will be analyzed as part of my course. I will provide you a copy of your interview transcript which you can review, revise and send back to me. If you approve the transcript, please send an acknowledgement within 48 hours informing me of receiving the transcript. In the event that I do not receive feedback within a week, I will assume that you have reviewed the document and that you are in agreement with the transcript. Upon receiving the transcript if revision is required, I will apply the requested edits and return for final review. I will follow up with you via the telephone if further edits are required and to finalize the interview.

Voluntary Nature of the Interview

This interview is voluntary. You have the choice to withdraw at any time before and during the interview.

Risks and Benefits of Being Interviewed

Being in this interview does not pose any risks beyond those of typical daily life. There is no benefit to you.

Privacy

Interview recordings and full transcripts will be shared with each interviewee. Transcripts with identifiers redacted may be shared with my university faculty along with my analysis. The interview recording and transcript will be destroyed as soon as I have completed my research.

Interview Questions

All of the interview questions will be open-ended to give you the opportunity to tell your experience. I will begin by asking questions that deal basic demographic questions followed by more complex questions. At this time, I will start recording the interview.

[*Demographic and general questions*]

1. What insurance type do you (have—patients) (accept—providers and administrators)?
2. Is there a visit duration policy at this practice? If so, what is the current visit duration policy of this practice?
3. What is the typical visit duration with a primary care provider during routine and annual physical visits?
4. How often do (you see your provider—patient), (typical patients come to see you—providers), (typical patients come to see their providers on an average—healthcare administrator leaders)?

[*Detailed open-ended questions*]

1. According to the literature on patient visit duration with PCPs, the average visit is 15-to 20-minutes. What have been your experienced with this visit duration?
2. Is the current patient visit duration with PCPs sufficient time to receive/provide holistic and high-quality care? Please explain why or why not.
3. How has the patient visit duration with PCPs impacted your care (patients), ability to care for patients (providers) and the overall health outcomes of patients (providers and practice administrators)?
4. What is your thought on the practice's role in improving patient health outcomes and improving patient satisfaction for low-income patients?
5. The triple aim framework is a healthcare framework developed in 2008 by the Institute of Healthcare Improvement (IHI) to improve care delivery to patients of the United States by focusing efforts on reducing healthcare cost per capita, improving patient satisfaction with care, and enhancing patient and population health outcomes. What are the triple aim application and practices employed at this clinic?
6. What are some of your experiences, reactions, or thoughts on patient-physician relationship? Please describe to me how that might be affected by this visit duration.

Closing Interview

I want to thank you for taking the time to participate in this interview. As I have stated earlier, I am the only person who will have access to the audiotape. I will transcribe the interview with in the next 72 hours and I will send it to you for an accuracy check and to make any revisions as you see fit. I would like you to review, revise, and send it back to me with revision or approval via email within 72 hours from the time you receive the transcript. If you approve the transcript, please send an acknowledgement within 48 hours informing me of receiving the transcript. In the event that I do not receive feedback within a week, I will assume that you have reviewed the document and that you are in agreement with the transcript.

Do you have any questions or concerns about the interview, transcription, time it will take to transcript, the study, or anything else?

[*closing dialogue and end of interview*]