


Transforming Primary Care in New York Through Patient-Centered Medical Homes: Findings From Qualitative Research

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Abstract

Background: The patient-centered medical home (PCMH) model, an important component of healthcare transformation in the United States, is an approach to primary care delivery with the goal of improving population health and the patient care experience while reducing costs. PCMH research most often focuses on system level indicators including healthcare use and cost; descriptions of patient and provider experience with PCMH are relatively sparse and commonly limited in scope. This study, part of a mixed-methods evaluation of a multi-year New York State initiative to refine and expand the PCMH model, describes patient and provider experience with New York State PCMH and its key components. **Methods:** The qualitative component of the evaluation included focus groups with patients of PCMH practices in 5 New York State counties (n=9 groups and 67 participants) and interviews with providers and practice administrators at New York State PCMH practices (n=9 interviews with 10 participants). Through these focus groups and interviews, we elicited first-person descriptions of experiences with, as well as perspectives on, key components of the New York State PCMH model, including accessibility, expanded use of electronic health records, integration of behavioral health care, and care coordination. **Results:** There was evident progress and some satisfaction with the PCMH model, particularly regarding integrated behavioral health and, to some extent, expanded use of electronic health records. There was less evident progress with respect to improved access and reasonable wait times, which caused patients to continue to use urgent care or the emergency department as substitutes for primary care. **Conclusions:** It is critical to understand the strengths and limitations of the PCMH model, so as to continue to improve upon and promote it. Strengths of the model were evident to participants in this study; however, challenges were also described. It is important to note that these challenges are difficult to separate from wider healthcare system issues, including inadequate incentives for value-based care, and carry implications for PCMH and other models of healthcare delivery.

Keywords

patient-centered medical home, primary care, patient perspectives, provider perspectives, qualitative research

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Background

The patient-centered medical home (PCMH) model, an important component of healthcare transformation in the United States (US),¹ is an approach to primary care delivery with the goal of improving population health and the patient care experience while reducing costs.² Core elements of the PCMH model include comprehensive and coordinated care, patient-centeredness, accessibility, quality, and safety.³ Within PCMH practices, the primary care team and the patient are responsible for managing all

health care needs directly or through coordination with clinicians in other settings.⁴

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The PCMH model has been operationally defined through several accreditation programs in the US, including through the National Committee for Quality Assurance (NCQA)⁴ and is incentivized by private and public payers, including Medicaid.^{1,5,6} First implemented in 2018, the New York State (NYS) PCMH model, which expands on the NCQA PCMH model,⁷ requires that practices seeking recognition through NCQA meet a higher number of criteria (40 core and 12 NYS-specific), emphasizing behavioral health integration, health information technology, care coordination, population health, and value-based payment contracting.⁷⁻⁹

Expansion of NYS PCMH was one of the main objectives of the NY State Innovation Model (NY SIM), which was funded by the Centers for Medicare and Medicaid Services from 2015 to 2020. As of December 2019, approximately 9500 NYS providers had attained PCMH recognition, and, of those, 5718 providers were recognized as NYS PCMH.⁷ According to NY SIM evaluation results, in cross-sectional analysis, PCMH-recognized providers had an overall net savings of \$2534 per member per provider (PMPP) compared to non-recognized providers, adjusted for patient and provider characteristics. When compared longitudinally using health claims data over a 3 years period, PCMH providers had a net savings of \$660 PMPP.¹⁰

As the PCMH name suggests, patients are intended to be at the center of the model. Qualitative studies that include patient and provider perspectives can elucidate progress toward patient-centeredness¹¹ and the relative significance of model components.¹² They can also reveal disconnects between documentation and implementation of PCMH model components—thereby informing operationalization and future iterations of the PCMH approach.

However, PCMH research most often focuses on system-level indicators (eg, shifts in healthcare use).¹ Research highlighting the patient perspective is more sparse and commonly limited in scope,^{13,14} including a focus on priorities and preferences for transformed practices rather than actual experience,¹⁵⁻¹⁷ few elements of the model,^{1,18} patients with specific health conditions,^{11,18} and/or reporting survey data,^{19,20} without the nuance offered by qualitative methods. Results are unclear,^{5,14,21} with some research suggesting PCMH recognition improves patient experience,^{19,21} while other studies suggesting there is no difference between PCMH and non-PCMH providers.¹ Studies reporting provider perspectives on PCMH are also limited,¹ despite the essential role of providers in the transformation process and the delivery of care.

In an effort to address the gaps in the literature—and to contribute to the growing body of evaluations¹⁹⁻²² of large-scale PCMH expansion—the current study, which was part of a statewide, mixed-methods evaluation of the NY SIM,¹⁰ explores experience and perspectives regarding PCMH

implementation and PCMH core components from a diverse population of NYS PCMH patients and providers.

Methods

The aim of this study is to identify strengths and limitations of the PCMH model, so as to continue to improve upon and promote its implementation. The findings reported here are derived from data collected as part of the qualitative component of the study, which was led by an experienced mixed-methods researcher (LW), with doctoral-level training in applied anthropology. The qualitative component included 9 patient focus groups (n=67 participants) and 9 interviews conducted with providers and practice administrators (n=10 participants) between 2018 and 2020. A focus group methodology was used with patients, so as to provide opportunities for participants to share perspectives and respond to the comments of one another. Interviews were conducted with providers and practice administrators in order to get a more detailed account of their experiences with PCMH transformation and the SIM, in general. Interviews and focus groups were conducted during the same time period.

Interviews and focus groups were audio recorded and professionally translated (if conducted in a language other than English) and transcribed. In addition, co-facilitators took written notes. To promote transparency and trustworthiness, reporting on the work is consistent with the Consolidated Criteria for Reporting Qualitative Research (COREQ).²³

Focus groups: Focus groups were held in private spaces at practice sites or in community locations in 5 NYS counties, representing 4 distinct regions of the state. About 7 groups were conducted in English, 1 in Mandarin, and 1 in Spanish. Diversity by region and language was intentional, to ensure the inclusion of perspectives from populations that may have differing needs and priorities and from geographic areas with distinct healthcare systems.

Participants for the English and Spanish-language groups were recruited through electronic platforms, such as craigslist. Participants were required to be 18 years or older and receiving primary care from a PCMH-recognized practice. To ensure eligibility, prospective participants completed an online screener that included basic demographic questions and provider and practice name (to cross check against a registry of PCMH-recognized providers). Participants for the Mandarin group were recruited and screened directly through a PCMH practice that serves a primarily Chinese patient population, including many who are limited English proficient; this alternative recruitment method was used due to resource and language limitations among study staff. At the start of the focus groups, participants completed a brief survey, in their respective languages, that included general demographic and health-related questions. Participants had no prior relationships with the research team.

Focus group facilitators followed a semi-structured guide, with main questions and prompts, designed specifically for this study (see Additional File 1). The same guide was used for all groups; it probed for specific elements of care expected in PCMH practices, including care coordination and referrals to services, behavioral health, health promotion, and use of electronic health records (EHR). The guide also included more general questions on use of primary care and other healthcare services; comfort and relationship with providers; wait times; health behaviors; health outcomes; and perceptions of quality and accessibility of care. Focus groups were approximately 60 min in length and were conducted in person. English groups were facilitated by an experienced focus group facilitator with expertise in the content area (KG); Spanish and Mandarin groups were conducted by trained bilingual colleagues. Consistent with standard the focus group practice, participants were asked to respond to the questions and to reflect on responses of other participants.²⁴

Interviews: Interviews were conducted with a convenience sample of providers and practice administrators from practices (primarily independent) that were working with SIM-funded technical assistance agents to transform to NYS PCMH or renew PCMH recognition. The technical assistance agents assisted with recruitment of interviewees; interviewees had no relationship to the interviewers outside of the study. The interviews followed semi-structured guides, designed specifically for this study, which varied slightly by role (ie, provider or administrator), but did not otherwise change over the course of data collection (see Additional Files 2 and 3). The guide included main questions and prompts focused on changes in care delivery with respect to behavioral health, care coordination, use of EHR, and addressing the social determinants of health. Interviews also included questions on perceptions regarding these changes, the process and logistics of PCMH transformation, and recommendations for future transformation efforts. Interviews were approximately 45 min in length and were conducted by 2 members of the study with experience conducting qualitative interviews and content expertise. Interviews were conducted in private spaces at the offices of participants.

Human subjects protections: All protocol documents were reviewed and approved by the Institutional Review Board at (blinded for review). Participants in the initial focus group received a \$30 incentive. The incentive was increased to \$50 for subsequent groups to ensure sufficient participation. Interviewees were not provided with a financial incentive. All participants received and completed a consent form prior to the start of focus groups or interviews. The consent form included information on the procedures and purpose (ie, conducted as part of an evaluation). In addition, focus group facilitators and interviewers introduced themselves and their role at the start of each activity.

Participants were reminded that their involvement was voluntary and they could discontinue participation at any time; none opted to do so. All individuals involved in conducting the study were working as researchers at the time the study was implemented.

Data Analysis

Transcripts were maintained and coded using NVivo version 12 (Melbourne, Australia). Given the differences in questions posed and in experience, separate codebooks were developed for the interviews and focus groups, following a combination of inductive and deductive strategies.²⁵ Each included pre-identified topics of relevance to the evaluation and topics emerging from the focus group and interview responses, respectively; emergent topics were identified by interview and focus groups facilitators, as well as coders. Codes included but were not limited to:

- Access to care;
- Health information and education;
- Electronic health record and electronic communication;
- Care coordination;
- Cultural competency and sensitivity;
- Mental and behavioral health; and
- Recommendations.

Differences in the interview versus focus group codebooks largely reflect differences in the questions, as alluded to above. For example, the interview codebook included codes regarding the process of practice transformation, which were not included in the focus group codebook, as they would have gone unused.

Two members of the research team independently coded 1 transcript from each category (ie, interviews and focus groups), then met to compare coding and discuss coding issues, including inconsistencies and lack of clarity. The codebooks were then revised and finalized, and code definitions were added. These final versions of the codebooks were used to recode the initial transcripts and to code those that remained.²⁶ Three members of the research team coded the transcripts, meeting frequently to review questions that arose. All had prior coding experience. Codes were used to organize data, to facilitate a systematic and efficient analytic process, and to reduce bias. Analysis was conducted through an iterative process, involving repeated reviews of the coded data from each set of transcripts, as well as the full transcripts—to ensure that coded extracts were understood within a fuller context. A directed content analysis approach²⁷ was used, which focused on practical topics and themes most relevant to the evaluation,²⁸ including PCMH attributes, the extent to which they had been successfully implemented, and perceptions thereof. Coded extracts on a particular topic (eg, behavioral health integration) from

interviews and focus groups were reviewed together, to ensure that multiple perspectives were carefully considered.

Results

Findings from the focus group and interviews are presented below. Following a description of participant characteristics, we highlight perspectives on 4 main attributes of the PCMH model: patient provider connections, use of EHRs, integrated behavioral health, and care coordination.

Focus Group Participant Characteristics

Table 1 presents demographic and socioeconomic characteristics of focus group participants. Just under half (42%) were White, 33% were African American/Black, 16% were Asian, and 13% were Hispanic/Latinx. Over 3-quarters (78%) attended college. About 54% were employed full or part time. Close to half (42%) were “always” concerned about money for food or housing over the last year.

Table 2 presents health and healthcare characteristics of focus group participants. Approximately half (49%) were covered by Medicaid, 19% were covered by Medicare, and 28% were covered by private insurance. Approximately 15% reported 1 doctor’s visit in the last year, 27% had 2 or 3 visits, and 49% reported 4 visits or more. The most commonly reported health conditions were depression or anxiety (33%) and asthma (30%).

Table 3 describes the roles of providers and practice administrators. The majority (n=8) had a management or leadership role.

Patient Provider Connections

Focus group participants and providers reported varied experiences with primary care. However, both recognized and described the value of strong patient-provider relationships, whereby providers supplement clinical information and direct services with support and personalized coaching that addresses the challenges that illnesses and treatment bring to individual patients.

My primary helped me with—they found cancer in me. And he was—I called and talked to him, went down to see him. He was instantly okay with, “You’re gonna go to get this done. You’re gonna have this test done. We’ll get the results and then we’ll go from there. . .” And his assistant called me, and I had known the assistant for years, too, calmly talked to me and persuaded me to go. (Patient Focus Group)

I think there’s a lot of value in being a warm and fuzzy doc, because it’s not all about “Mr. Jones, we’re monitoring your blood pressure,” but it’s “Mr. Jones, I have bad news about your chest x-ray, and I wanna work with you to see what we can do about that mass that we just found.” (Provider/Practice Lead)

Table 1. Focus Group Participant Demographic and Socioeconomic Characteristics (N=67).

Characteristics	n (%)
Age	
18-29	12 (18)
30-39	14 (21)
40-49	15 (22)
50-59	10 (15)
60+	14 (21)
Missing/no response	2 (3)
Gender	
Female	30 (45)
Male	36 (54)
Non-binary	1 (1)
Race/ethnicity^a	
Asian	11 (16)
Black/African American	22 (33)
Hispanic/Latinx	9 (13)
White	28 (42)
Other	1 (1)
Main language spoken at home^a	
English	53 (79)
Mandarin	8 (12)
Spanish	3 (4)
Other	2 (3)
Missing/no response	3 (4)
Education	
Did not graduate from high school	4 (6)
High school graduate or GED	10 (15)
Some college	18 (27)
Associates degree, technical, or vocational school	9 (13)
Bachelor’s or master’s degree	26 (39)
Work status^a	
Employed (full or part time)	36 (54)
Student	4 (6)
Not working, retired, or disabled	27 (40)
Concerned about money or food in last year	
Always	28 (42)
Sometimes	16 (24)
Rarely	11 (16)
Never	11 (16)
Missing/no response	1 (1)

^aMultiple responses permitted.

Deviation from the ideal patient-provider relationship was commonly described. Participants appreciated the knowledge, skills, and sensitivity of the providers they saw, but regretted time constraints imposed on patient-provider interactions. They commonly attributed these constraints to conditions outside the control of the provider, including healthcare shortages in their communities or the demands of a system that prioritizes volume of services. They recognized that providers were required to balance priorities and

Table 2. Focus Group Participant Health and Health Care (N = 67).

Characteristics	n (%)
Health insurance ^a	
Medicaid	33 (49)
Medicare	13 (19)
Private	19 (28)
Other	11 (16)
Doctors visits in the past year	
1	10 (15)
2 or 3	17 (27)
4 or more	33 (49)
Missing/no response	7 (10)
Health conditions ^a	
Arthritis	8 (12)
Asthma	20 (30)
Cancer	16 (24)
Chronic pain	12 (18)
COPD	7 (10)
Depression or anxiety	22 (33)
Diabetes	14 (21)
Drug or alcohol issues	2 (3)
Heart disease	5 (8)
High blood pressure	18 (27)
High cholesterol	10 (15)
HIV/AIDS	4 (6)
Mobility impairment	4 (6)
Obesity	13 (19)
Other	18 (49)

^aMultiple responses permitted.

Table 3. Roles of Providers and Practice Administrators (N = 10).

Role	n
Practice lead/managing partner	4
Nurse practitioner	1
Registered nurse and care coordinator	1
Practice manager/administrator	3
Vice president/ambulatory care	1

appreciated when providers opted to take the time necessary to address their needs.

Sometimes I feel like they try to push you out, because like I said, he's the only doctor in the community, so he's got like thirty patients sometimes to see in one day. I just feel like he tries to spend a minimal time with people. (Patient Focus Group)

They have to see – I don't know the number, 20-30 people a day. So, they're like, "Well—and if it hurts, come back in three weeks, but let me know. Next patient." (Patient Focus Group)

I can tell [my doctor is] trying to get through things kind of quickly. But then if I'm talking about problems I have, she slows down and she really gets to what's going on. All my symptoms and stuff like that. And then next thing you know, you're in there for maybe forty minutes. (Patient Focus Group)

Barriers and Facilitators to Accessing Care

PCMH recognition requires that practices have improved accessibility: providers reported they use a combination of extended hours and access to telehealth services to meet this requirement. A small number of focus group participants also reported that their providers had evening or weekend hours. Several reported that their providers had open-access visits (ie, visits not requiring a pre-scheduled appointment), which patients appreciated. They noted the flexibility open-access offered, given their own changing circumstances and its suitability for urgent healthcare needs.

She's been – always been really good about the appointments. You could call her up and say, "I'm really – something's" – and a lot of times she's like, "Come in right now." (Patient Focus Group)

In most focus groups, participants described some difficulties with scheduling (annual physicals, in particular), though they expressed more complaints about wait times on the day of a visit. They felt these wait times were disrespectful and hypocritical, given requirements for patient timeliness, as well as the short lengths of most visits.

If I'm ten minutes late they won't see me. Yet, if I was on time I would be sitting in the waiting room for at least ten minutes and then in the back I'd sit for another twenty minutes, so what's it matter if I was late or not? So, it's like I'm on their time, and my time doesn't matter. (Patient Focus Group)

Patients and providers noted continued use of urgent care and the emergency department for services that could have been provided in the primary care setting. Reasons cited differed somewhat by respondent type, with patients more likely to report issues related to access and providers more likely to focus on factors related to patient preferences. Providers described consistent outreach and education in order to change patient behavior, but felt the messages were not having the desired impact.

My doctor wasn't taking appointments, so I went to the emergency room. (Patient Focus Group)

[Patients use the ER] because it's convenient for them, closer to home. They don't have to get out of work, although we have extended our hours. . . that's why the follow-up care is important. The phone calls are important to let them know, "Hey, there's a nurse on call twenty-four hours a day." (Provider/Care Coordinator)

The extended hours, we actually have addressed with our telemedicine program. . . it's still in the beginning phases, but we're trying our best to push it and make it second nature for the patients and for the providers. (Provider)

Participants in the 2 Spanish and Mandarin groups reported that bilingual providers and interpretation services were available at the practices they used and that providers were sensitive to language access issues. Within the Mandarin group, participants noted that people chose the practice because of the language skills and cultural compatibility of the providers and staff.

My mom does not speak Mandarin, then they would find a translator that speaks Fuzhou dialect, and talk slowly to her. Although there are many patients out front, he would still do the same. (Patient Focus Group)

If you need them, the nurses – because before going to see the doctor you tell your nurse you need a [Spanish] interpreter. I imagine that's the policy, to tell the nurse. So, I see that when the patient gets to the doctor, the translator is already there. (Patient Focus Group)

Use of EHRs

Most participants in the focus groups were comfortable with their providers using EHRs and appreciated their value for storage of comprehensive health information that can easily be searched, reviewed, and shared—improving quality and continuity of care. A number of patients also appreciated greater access to their own health information for practical reasons and to increase their own understanding of their health issues.

I feel fine [about the EHR] – even better, because I know that way they won't forget, and that if another doctor has to see me, there's a note on it already. . . I go to the occupational therapist that is in another building, another day, they can – when they go on the computer, the note comes up. (Patient Focus Group)

I was in a car accident in – end of October. And two days later, my neurologist called and asked how I was. And then, the next day, my primary care doctor, because they all got the report that I was at the emergency room. (Patient Focus Group)

It always used to seem so mysterious in the old days when they would tell you what was wrong, but you really couldn't see all the entire report or anything. So, I like it a lot better that they share it now. You can just go on [the EHR], look yourself, and figure it out. (Patient Focus Group)

A small number of participants expressed a more negative view of the EHR. Several felt the data entry requirements negatively impacted the quality of the patient-provider interaction; a few others complained that providers

gathered information for the EHR but did not use what was available there, asking patients the same questions repeatedly and not checking information that may have been recorded by other providers.

[The provider will] come in the room and he'll shake my hand and we'll greet each other, and then he'll ask me what's wrong and I tell him what's wrong, and then he goes over to the computer. He's like, all right, well let me pull up your chart. That beginning personal touch is lost, because he has to go on the computer and look everything up instead of focusing on what I said was wrong. (Patient Focus Group)

It's also sometimes weird to me when I go to a doctor's visit and they're like, "Oh, well what medications did your psychiatrist put you on?" Or whatever. Then you have to remember them. And I was like, "Don't we have [an EHR] or whatever?" I thought all of that information was— all of our care was linked so they could see everything. (Patient Focus Group)

Providers also reported that the need to use a computer, and the practice alerts built into the EHR, effected the progression of visits and interpersonal communication, sometimes forcing them in directions inconsistent with the patient's or the provider's main concerns (eg, prompting questions regarding preventive care during an acute care visit). As illustrated below, providers considered these shifts in direction particularly problematic if they resulted in inappropriate recommendations, for example recommending services to a low-income patient that required a copay.

They come in for headache, back pain, itchy skin, depression. [With the EHR] you've got to do all these other things that's not on their plate. That's maybe the most difficult thing is to add things to a visit that are not on the provider's plate, not on the patient's plate, but on [the system's] plate. (Provider/Practice Lead)

They have no money to buy food. And they're not calling the doctor. So, we call them and say, "Well, not only are we going to call you every month, we're going to charge you deductibles." "Don't call me, I'm doing fine," even though they're not doing fine. (Provider/Practice Lead)

Patients that reported electronic communications with providers described positive experiences; many also reported using a patient portal to check lab results, schedule appointments, and refill prescriptions. They particularly appreciated the time saved in completing these tasks. Participants in the Spanish- and Mandarin-language groups described lower use of electronic communications (see, eg, the third quote below, from the Mandarin group). Providers also expressed some concern regarding disparities in access to electronic communication, most often noting that older patients have poorer access.

I've had really good luck with MyChart. That way, I can make appointments, I can send a message to my doctor, I can – it seems faster than calling and sitting on hold for ten minutes. (Patient Focus Group)

I needed a refill on a prescription at this one, and since I messaged [my provider] through the portal and the prescription—I was getting texts from [the pharmacy] saying that the prescription was ready. At the same time [my provider] had sent me a message. Within fifteen minutes of each other. (Patient Focus Group)

He would send a fax. He would give us a copy of the data, but if we lose it, there is a charge for a second copy. (Patient Focus Group)

Integrated Behavioral Health

Experiences with integrated primary care and behavioral health were often positive. Many participants in focus groups reported feeling comfortable discussing emotional or mental health concerns with their respective providers and appreciated the efficiency of integrated care. Those who did not want to speak to their primary care providers about mental health offered reasons that included lack of confidence in the mental health-related knowledge and skills of primary care providers and concerns regarding mental health stigma. Other concerns included fear of over-medicating and fear that the provider would attribute physical health conditions to depression and anxiety. These differing perspectives included:

Having my primary care come directly from where I get my mental health services is really helpful in feeling accepted [by] my doctor. So, she already has access to that. And she still doesn't judge me. (Patient Focus Group)

My primary care doctor knows what's going on with me physically and mentally. And he's the one that put me on antidepressants and anti-anxiety medication, both at the time that I was diagnosed with cancer. So, he's connected to my mental care and all my other doctors. (Patient Focus Group)

Just because, say, you tell them your mental health history, and you've been in a psychiatric ward. They start to look at you differently. (Patient Focus Group)

When I was open about my mental health to my – the first person that I was seeing, everything that I was experiencing became about, "Well, you're depressed." Or, "You have these GI symptoms because you're anxious." . . . To consistently be told that everything is because I'm sad or whatever. . . to not be believed by someone who's supposed to be treating you, and believe in you, and affirming you is really, really extremely discouraging. (Patient Focus Group)

Providers had positive perspectives on integrated behavioral health, noting that it extended the capacity of their practices and allowed them to better meet patients' mental health needs—which they recognized were significant. Methods to integrate behavioral health care into PCMH practices differed, with some providing on-site access to a mental health provider, and others relying on referrals.

If you talk to enough good providers. . . they will tell you that anywhere from ten to ninety-five percent of that office visit is a behavioral health visit. . . So, the opportunity to have someone in my office that I could walk [patient name] over to and say, "[patient name], I'm glad we got to speak, but I've got [mental health provider name] here, and she's gonna spend a little bit more time with you and see if we can put together what you need." And, I think that is incredibly powerful. (Provider/Practice Lead)

I've had many children that come in, and [parents] think they have ADHD, and I send them to our [social worker] – and lo and behold, that's not what it is. It's the turmoil, what's going on in their home, those kinds of things that—and, I say to people, "I don't wanna put your kids on meds for ADHD when I'm not sure that's what they have." (Provider/Care Coordinator)

Care Coordination

Focus group participants reported varied experiences with care coordination. Some described effective referral arrangements offered through their providers. However, they recognized that referrals were often constrained by health systems and payers, and they expressed frustration with these constraints—and with providers who were unaware of network issues. System limitations were more apparent in safety net systems and outside large cities where access to specialists was more limited. Providers noted that feedback from specialists was inconsistent, which hindered primary care providers' ability to coordinate care.

I had a severe eczema issue before, and at the time I was in a HMO. . . my issue wasn't resolved, but there were no other specialists in network. So, it was like when that last – they said, "Try this," I was given medication, and when that didn't work, it was basically like they were like, "That's it, there's no other person to see, there's no other referral." (Patient Focus Group)

They'll refer you to somebody, but then they don't take your insurance. So then, you're back to square one. You've got to call them again. It's – there's no communication between providers, insurance, or anything. (Patient Focus Group)

We were basically asking, ". . . If you see this patient, please, send us this kind of information back. Or at least notify us." Stuff like that. When our patients are there, please, do these things. And not many specialists want to be told what to do by a family doctor. (Provider)

Discussion

The NYS PCMH model is designed to make primary care practices more accessible, responsive, and proactive with regard to patient needs.⁸ Our findings from patient focus groups and interviews with providers and practice administrators were relatively consistent and suggest there is progress and some satisfaction with the PCMH model, across regions and linguistic groups. Satisfaction was noted with regard to integrated behavioral health on the part of both the patient and provider and use of a patient portal on the part of the patient, although disparities in access to, and comfort with, electronic systems were evident. Patients that used practices with open-access visits appreciated the responsiveness of those systems, but—overall—there was less evident progress with respect to improved access and reasonable wait times, which caused patients to continue to use urgent care or the emergency department as substitutes for primary care. This occurred despite providers reporting that they had created opportunities, including telehealth and extended hours, which may have met these needs. However, investments in and the use of telehealth increased exponentially as a result of the COVID-19 pandemic,^{29,30} so the perspectives of some patients (eg, patients who are comfortable with technology and have private space at home for a remote visit) was likely to have changed since the time the data were collected. Challenges remain with respect to coordination with specialty care, in large part reflecting health system and payer restrictions.

Our study has some limitations. First, the number of interviews with providers was relatively small. Second, in some cases, focus groups and interviews were conducted shortly after PCMH transformation had occurred; a longer time frame may have yielded different results. As noted above, perspectives on telehealth may be outdated, given the significant expansion of remote services due to COVID-19. Strengths included the geographic and some linguistic diversity across patient focus groups and the inclusion of both patient and provider perspectives. We are uncertain regarding data saturation, particularly for the focus groups conducted in languages other than English, but did observe consistent themes—within and across data collection methodologies, as described above.

Conclusions

The PCMH model implemented in NYS is promising and integrated behavioral health—a NYS-specific requirement of PCMH—appears to be one of its strengths. Impediments remain, including limited time for visits and inadequate access to specialists, in some cases. However, consistent with findings from PCMH implementation in other states,²¹ reported issues and concerns are difficult to separate from

wider healthcare system challenges that make the implementation of the PCMH model challenging. These challenges include incentivizing payers to more actively participate in value-based care, incentivizing improved data sharing across systems, and resource limitations in safety net systems and in certain geographic areas.

Given the lessons being learned from the COVID-19 pandemic and the opportunities for improved healthcare access included within the American Rescue Plan (ARP) of 2021,³¹ it is critical to understand the strengths and limitations of the PCMH model, so as to continue to improve upon and promote it. Millions of people are expected to gain health insurance coverage through the ARP and, as such, comprehensive and effective primary care will continue to be important, in order to be able to live up to the promise of delivering high quality, patient-centered care to everyone.

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Authors Contributions

1. LW oversaw the design and analysis of the qualitative component of the evaluation, participated in data collection and analysis, and led the preparation of the manuscript.
2. KG oversaw data collection and coding, facilitated most of focus groups and interviews reported on here, and had principal roles in data analysis and writing results.
3. MW contributed to the design of the qualitative component, reviewed preliminary and final analysis, and contributed to early and final drafts of the manuscript.
4. ED had a principal role in data collection and coding, conducted preliminary analyses, and led preliminary drafts of the manuscripts.
5. FJ contributed to the design of the qualitative component, analysis of the data, and reviewed the manuscript.
6. JP directed the broader evaluation that encompassed this work, reviewed preliminary and final analyses, and contributed to early and final drafts of the manuscript.

All authors read and approved the final manuscript.

Declaration of Conflicting Interests

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Ethics Approval and Consent to Participate

The research was approved by the Institutional Review Board of The New York Academy of Medicine and all participants provided signed consent. The reference number is: 031517.

Consent for Publication

No individual data or details are included.

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Data Availability

Data generated in this study and reported on here are available from the corresponding author on request.

Supplemental Material

Supplemental material for this article is available online.

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