

PATIENT SATISFACTION IN AN ACADEMIC INTERNAL MEDICINE CLINIC COMPARED TO A FEDERALLY QUALIFIED HEALTH CENTER

Patient satisfaction with healthcare services has long been measured by health insurance companies, and more recently has been used by them as a factor in determining reimbursement to providers of healthcare. Given the relatively smaller proportion of commercially insured patients in safety net settings, safety net providers have been at less financial risk from low patient satisfaction ratings. As increasing numbers of patients, however, due to loss or lack of employer based health insurance, seek care in settings traditionally considered safety net, patient satisfaction in these settings will have increased relevance. The principal purpose of this study was to compare patient ratings and perceptions of primary health care experience between two models of primary care safety net providers, a federally qualified health center (FQHC) and a primarily resident-staffed academic internal medicine clinic. We administered the Group-Level Consumer Assessment Health Plan Study (G-CAHPS) survey tool to measure patients' experience within each setting. Patients rated the academic internal medicine training site higher in the following domains: getting care when needed; doctors' communication skills; coordination of care; and wait time before being taken into the exam room. In other domains, patients' ratings in the settings were not substantially different. There were no domains in which patients rated the FQHC higher than the internal medicine training site. These findings suggest that barriers to patient satisfaction may exist in some FQHCs to a greater degree than in some resident-staffed academic internal medicine clinics.

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INTRODUCTION

Patient satisfaction is becoming increasingly relevant as a basis for payment. In the marketing of a company's healthcare services, high satisfaction ratings are a vital component. The purpose of this study was to determine the difference, if any, in patient satisfaction between patients who receive their healthcare in an academic internal medicine clinic and those who receive their care in a federally qualified healthcare clinic (FQHC).

We reviewed studies¹ that examined insured patients' satisfaction with their primary healthcare services received. Few studies, however, assessed un/under-insured patients' satisfaction in low-income settings. The literature concluded that low-income individuals were less satisfied with care received, regardless of insurance type.² In this study, we compared patient satisfaction between a community primary health clinic that served a predominantly un/under-insured population (85% uninsured, 11% Medicaid, 4% other) and an academic internal medicine clinic that also served a substantial number of un/under-insured patients (25% commercial, 43% indigent, 31% Medicare, and 1% other payers). To address this issue, a trained interviewer administered the G-CAPHPS survey tool to patients in each setting while they waited for appointments with their primary care physicians. The G-CAPHPS is a survey tool designed to measure consumer experience with their medical groups.

METHODS

The G-CAHPS survey tool was administered at three different federally

qualified healthcare clinics at different locations in an urban city area. Based on patient volume at each of the clinics, a convenience sample size was determined. A schedule guideline to obtain a wide range of sampling days and times was provided to us. On unannounced days, we notified the clinic manager of our presence in the waiting room and confirmed the procedure for dissemination and collection of surveys. We offered patients the opportunity to participate in the survey as they arrived for their appointments. If the participant agreed to complete the 15–20 minute survey, the survey was administered. They were instructed to read the information sheet, which provided details regarding purpose, procedure, risk/benefit, and confidentiality. Participants also had survey instructions read to them. Study eligibility criteria were as follows: participant was a current patient of the physician group; and has received care from a group provider in the last 12 months not including the current visit. If the participant met eligibility requirements, they were instructed to begin the survey. Assistance was provided to people who needed help reading or understanding the survey questions. If the participant was called for their appointment prior to finishing the survey, they were invited to take it with them and to complete it while waiting in the exam room. They were instructed to return the completed survey to the interviewer before leaving.

Once our survey sample goal was reached, all surveys were reviewed for accuracy and then assigned an ID number. Data from all complete surveys were entered into a database and analyzed using the SAS statistical soft-

ware and the analysis routine from G-CAHPS. Because the patient populations, administration and operations were comparable, the three FQHC sites results were pooled and analyzed as one site. The mean scores obtained from the FQHCs were then compared with those obtained from an earlier administration of G-CAHPS at the academic internal medicine trainings site. The G-CAHPS analysis produced results in the following domains: getting care when needed; getting care quickly; how well doctors communicated; courteous and helpful office staff; rating of personal doctor or nurse; rating of specialist seen most often; rating of all health care; explanation of tests/prescriptions; preventive counseling; coordination of care; and wait before taken to exam room.

DISCUSSION

We conclude that patients in the internal medicine training site rated their experience with primary health

care higher than that of patients receiving their primary health care in the FQHC. The internal medicine training site scored higher in the four following areas: getting needed care; doctors' communication; doctors/nurses informed and up-to-date about care from specialists; and wait time before being taken into the exam room. These findings suggest that some FQHCs may be facing greater barriers in achieving patient satisfaction than the some resident staffed academic internal medicine clinics.

Physician turnover is often cited by patients as a reason for being dissatisfied with primary care received in FQHCs. Physicians in FQHCs, for various reasons and in contrast to academic clinics, share greater barriers in providing adequate health care. And due to physician dissatisfaction, they resign as advancement opportunities open. Physicians are motivated to leave in pursuit of professional development, higher incomes, and improved working hours.³

Although our study has concluded that patients' experience and satisfaction is higher in an academic site, the limited number of responses received may have contributed to the difference in responses. Although this study was adequate for our purpose, replications of this study with larger sample sizes are recommended to conclude statistical data. To improve the quality of care in FQHCs, more effort should be focused on providing higher quality health care to better satisfy their patients.

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