Identifying Successful Practices to Overcome Access to Care Challenges in Community Health Centers: A “Positive Deviance” Approach

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Abstract

Background: Despite health care access challenges among underserved populations, patients, providers, and staff at community health clinics (CHCs) have developed practices to overcome limited access. These “positive deviant” practices translate into organizational policies to improve health care access and patient experience.

Objective: To identify effective practices to improve access to health care for low-income, uninsured or underinsured, and minority adults and their families.

Participants: Seven CHC systems, involving over 40 clinics, distributed across one midwestern state in the United States.

Methods: Ninety-two key informants, comprised of CHC patients (42%) and clinic staff (53%), participated in semi-structured interviews. Interview transcripts were subjected to thematic analysis to identify patient-centered solutions for managing access challenges to primary care for underserved populations. Transcripts were coded using qualitative analytic software.

Results: Practices to improve access to care included addressing illiteracy and low health literacy, identifying cost-effective resources, expanding care offerings, enhancing the patient–provider relationship, and cultivating a culture of teamwork and customer service. Helping patients find the least expensive options for transportation, insurance, and medication was the most compelling patient-centered strategy. Appointment reminders and confirmation of patient plans for appointments reduced no-show rates.

Conclusion: We identified nearly 35 practices for improving health care access. These were all patient-centric, uncovered by both clinic staff and patients who had successfully navigated the health care system to improve access.

Keywords
access to care, key informant interviews, qualitative data analyses, positive deviance, complexity science, underserved populations, community health centers, access barriers

Introduction

Health care in the United States continues to be at a crossroad, with its quality and economic security at risk due to system problems in health care delivery.1 Limited access to health care is an important equity and social issue in the United States and persists as a significant burden on its population.2 Low-income people, as well as racial and ethnic minorities, are more likely to receive lower quality of care and encounter more obstacles to health care access compared to other groups.3 A recent study found that among adults aged 18 to 64 years who had no...
Table 1. Information on the CHC Systems, Patient Served in a Year, the Number of Physical Service Delivery Sites, the EHR Used, and Appointment Scheduling Method Currently in Place.

| CHC   | Patients/Year | Sites | EHR Vendor      | Scheduling Type       | Setting   | Number Interviewed |
|-------|---------------|-------|-----------------|-----------------------|-----------|--------------------|
| CHC-S | 7324          | 1     | eClinicalWorks  | Modified open access  | Urban     | 6 5                |
| CHC-H | 59 286        | 12    | eClinicalWorks  | Modified open access  | Urban     | 6 7                |
| CHC-N | 13 002        | 3     | NextGen         | Traditional           | Urban     | 8 9                |
| CHC-O | 20 703        | 9     | Athena Health   | Modified open access  | Urban     | 6 7                |
| CHC-R | 42 092        | 8     | NextGen         | Traditional           | Urban     | 5 6                |
| CHC-P | 4764          | 2     | GE Centricity   | Traditional           | Rural     | 7 6                |
| CHC-V | 7525          | 5     | GE Centricity   | Traditional           | Rural     | 5 9                |
| Total | 154 696       | 40    |                 |                       |           | 43 49              |

Abbreviations: CHC, community health center; EHR, electronic health record.

insurance in the prior year, 1 (22%) in 5 had an unmet medical need related to cost.4

Access to health care means having “the timely use of personal health services to achieve the best health outcomes.”2 Good access to care is comprised of 3 distinct steps: (1) achieving entry into the health care system, (2) obtaining access to essential health care services, and (3) locating providers that can meet patients’ individual needs and with whom they can communicate and build a respectful and trusting relationship.3 Access to health care is critical for optimal health and wellness; thus, addressing obstacles that occur at each of these steps is important for improving the patient experience and health outcomes.

Enhanced access and continuity of care are also core components of patient-centered care.5,6 Several interventions have been used to enhance access to primary care. The existing strategies have been classified into 5 categories: (1) practice reorganization, (2) patient support, (3) new services, (4) financial incentives, and (5) workforce development.7 The aim of the current study was to investigate barriers and effective practices in community health centers (CHCs) to improve access to primary health care, in outpatient ambulatory care settings, for underserved populations: low-income, uninsured or underinsured, and minority adults and their families. Although we sought strategies within all 5 categories, our focus was on practice reorganization, patient support, and new services.

At the onset of this project, approximately 1.5 million low-income individuals had inadequate access to health care services in Indiana,21 most of whom would turn to CHCs for their care. CHCs are nonprofit organizations that “provide affordable, high quality, comprehensive primary care to medically underserved populations, regardless of their insurance status or ability to pay for services.”15(p3) In 2014, there were 23 CHC systems in Indiana serving over 393 000 patients, the majority of which were low income and uninsured or underinsured.15 CHCs vary in the types of services available, with some having laboratory testing and pharmacies on-site. In order to understand and address barriers to accessing care, we formed a collaborative with 7 Indiana CHC systems (see Table 1), spanning 40 clinic sites.

This study was the first of a 3-phase redesign project aimed at improving access to primary care in CHCs. In this study, we report the patient-centered solutions identified for managing challenges particular to providing access to care for underserved populations that emerged from a thematic analysis of stakeholder interviews.

Methods

Semi-structured interviews were conducted over a period of 18 months with key informants (patients and staff) at each participating CHC system (Table 1) as a means to understand primary care access challenges and corresponding practices that individuals have found helpful in overcoming limited access.

We took a unique approach in our study recruitment, applying a contextual framework involving “positive deviance” (PD) from complexity science, in order to identify innovative, successful practices of key informants, whose practices enable them to find solutions to overcome health care access problems.8,9 Positive deviance is a bottom-up improvement approach that considers people doing the work as experts and focuses specifically on utilizing them as a typically untapped resource. Individuals or groups whose behaviors or practices enable them to find better solutions to prevalent, seemingly intractable problems are considered “positive deviants.”10 Thus, the PD approach was used here in an attempt to discover these positive deviants within a population of CHC patients and frontline staff and engage them in identifying solutions to existing access barriers. Positive deviance has demonstrated its efficacy in solving health-related problems8,9,11,12 and supporting improvement and redesign efforts in health care organizations.13,14 The PD framework was applied both for recruiting targeted participants and as a lens for data analysis.

Interview Methods

Interviews were conducted face-to-face with a sample of CHC managers, providers, and other staff, as well as patients seeking care at those clinics. We asked our clinic liaison (typically the clinic manager or upper-level management) to select patients...
who demonstrated successful strategies or practices to gain access to health care and staff who had developed successful practices in delivering care. While not all the individuals that we interviewed could be categorized as positive deviants, successful practices for improving health care access were identified across all interviews.

Site Selection
CHCs were invited to participate via a mailing to administrators describing the project, expected responsibilities, and benefits. Participating clinics were selected based on expressed commitment, a diverse patient population, and willingness to share data and participate in implementing an intervention. Participating clinics were diverse according to both patient- and clinic-level factors (Table 1).

Data Collection
Prior to clinic visits, clinic liaisons (typically the clinic manager or upper-level management) identified patients and staff who demonstrated successful strategies or practices to improve patient health care access. Of those identified, we recruited staff across a range of key roles to understand clinic processes from various vantage points and how processes relate to patient’s health care access. Research staff completed the informed consent process with all participants individually prior to their interview. Semi-structured interviews focused on successful patient-centered practices to overcome availability, accommodation, and affordability challenges (see Table 2 for example questions). Patient participants were compensated with a US$20 gift card; clinic staff and providers were not directly compensated, but the clinic received a stipend to account for employee time. All interviews were conducted in a private room, recorded, and transcribed. No individual or clinic identifiers were retained in the transcripts. The institutional review board at our university approved all procedures.

Data Analysis
We conducted a qualitative thematic analysis\textsuperscript{16} of the transcribed interviews. The research team developed a code book after reviewing 3 complete transcripts. Using an iterative consensus-based process, members coded data independently and then met to discuss discrepancies and reach consensus. The final consensus for each pair of reviewers was entered into NVivo.\textsuperscript{17} After coding 10\% of the data in this manner, team members independently coded transcripts. After coding, the data were compiled and each category was reviewed for upward abstraction. Specifically, the data were represented at a higher level of abstraction so that interview responses could be integrated across cases to show patterns of strategies.

Results
We conducted a total of 92 key informant interviews, split between clinic patients (42\%) and clinic staff (53\%; Table 3). Participating staff included providers, managers, nurses (registered nurses [RN] and licensed practical nurses [LPN]), medical assistants, schedulers, front desk staff, social workers, care navigators, and billing coordinators. Roughly half (47\%) had worked in the clinic for more than 5 years. The majority of participating patients were uninsured or underinsured (84\%) and had been patients at the clinic for a median length of 6 years. Patients reported their health status to be “poor” (12\%), “fair” (42\%), “good” (39\%), or “very good” (7\%).

Interview themes related to improving access are shown in Table 4. One of the central contributions from this work was a list of 35 practices for improving health care access (Table 5). These strategies were all patient-centric, uncovered by both clinic staff and patients who had surmounted barriers to

### Table 2. Sample of Interview Questions Used With Patients.

| Question                                                                 | Clinic Staff | Patients |
|-------------------------------------------------------------------------|--------------|----------|
| What do you experience as the most common barriers or challenges to getting seen in the clinic when needed? | % (n = 49)   | % (n = 43) |
| What approaches have you found to be helpful in getting you in to see a provider more quickly or easily? | Male         | Female    |
| What approaches does your clinic use to help patients like you get patients seen more quickly? | 6            | 14        |
| When you [or your child] get ill and what kind of information do you feel you need to decide whether to go into the ER, or wait to be seen in the clinic? | 18-24        | 7         |
| Was there any time during the past 12 months when you put off getting medical care you thought you (your child) needed? | 25-34        | 31        |
| Have you ever had a time when you were unable to make an appointment? | 35-64        | 48        |
| Do you use technology in any way to get health information? | 65+          | 14        |
| What sorts of technology do you currently use/would you like to use to help schedule clinic appointments? | Non-Hispanic white or Euro-American | 62 |
| If you could (wave your magic wand and) change one thing about your current clinic’s access to care or care experience, what would it be? | Black, Afro-Caribbean, or African | 14 |
|                                                                              | Latino or Hispanic American | 24 |
|                                                                              | Years with clinic |   |

### Table 3. Summary Characteristics of Interviewees.

| Characteristic                              | Clinic Staff | Patients |
|---------------------------------------------|--------------|----------|
| Gender                                      | Male         | Female   |
| Age                                         | 18-24        | 7        |
|                                             | 25-34        | 31       |
|                                             | 35-64        | 48       |
|                                             | 65+          | 14       |
| Race                                        | Non-Hispanic white or Euro-American | 62 |
|                                             | Black, Afro-Caribbean, or African   | 14 |
|                                             | Latino or Hispanic American         | 24 |
| Years with clinic                           | <5           | 26       |
|                                             | ≥5           | 23       |

Abbreviation: ER, emergency room.
illiteracy and poor understanding of health care delivery. Illiteracy and poor understanding of expanding care offerings at the clinic, and socializing patients and low health literacy, identifying low cost or free resources, response to patient challenges included addressing illiteracy. Patient-centered practices to improve health care access in our third and final phase of our study. Based on the study goals, we focus on fully prioritized in a later part of our study, then used to identify the clinic interventions for improving access in our third and final phase of our study. Based on the study goals, we focus on fully describing the creative strategies and PD approaches uncovered during the interviews that resonated across all of the thematic categories (Table 4).

| Overarching Themes                  | Subcode (Frequency of Mention) |
|-------------------------------------|---------------------------------|
| Health care access/health IT access | Challenges (253)                |
| Health needs between visits         | Challenges (173)                |
| Patient experience with health care delivery | Challenges (76)    |
| Provider and staff issues           | Challenges (78)                 |
|                                   | Strategies (70)                 |
|                                   | Challenges (164)                |
|                                   | Strategies (361)                |
|                                   | New patient appointment (27)     |
| Late/no show                       | Patient provided reason (43)     |
|                                   | Observed trends (84)             |
|                                   | Problems (35)                   |
| Clinic services familiarity         | Challenges (24)                 |
|                                   | Strategies (117)                |
| External to organization            | Problems (49)                   |
|                                   | Strategies (60)                 |
|                                   | Problems (37)                   |
|                                   | Strategies (40)                 |
| Portability of patient information  | No subcode (4)                  |
| Technology                          | Access to Internet (55)         |
|                                   | Uses Internet (35)              |
|                                   | Access to computer (31)         |
|                                   | Use cell phone (64)             |
|                                   | Use text messaging (38)         |
|                                   | Use e-mail (4)                  |
|                                   | Portal to EHR (17)              |
|                                   | Pt preference or method         |
|                                   | communication w/clinic (62)      |
| Patient portal to EHR              | Implementation status (32)       |
|                                   | Potential problems (73)          |
|                                   | Rollout strategies (20)          |
|                                   | Portal functionality (65)        |
| Clinic and provider issues         | Problem (16)                    |

Abbreviations: IT, information technology; EHR, electronic health record; pt, patient.

Healthcare access. This list of practices was refined and prioritized in a later part of our study, then used to identify the clinic interventions for improving access in our third and final phase of our study. Based on the study goals, we focus on fully describing the creative strategies and PD approaches uncovered during the interviews that resonated across all of the thematic categories (Table 4).

**Positive Deviance Practices to Improve Patient-Specific Challenges**

Patient-centered practices to improve health care access in response to patient challenges included addressing illiteracy and low health literacy, identifying low cost or free resources, expanding care offerings at the clinic, and socializing patients to health care delivery. Illiteracy and poor understanding of chronic disease management was identified as a major barrier to access. One provider discussed how the clinic had applied a candid approach to evaluate patients’ ability to read by directly asking them, “Can you read?” Being direct in identifying challenges was considered important in determining patient education needs.

You just have to go there and be honest...I found 4 patients [1] morning—none of them could read and all of them were on at least 7 or 8 medicines. (Physician)

Helping patients find the least expensive options for transportation, insurance, and medication stood out as among the most consistent patient-centered strategies across clinics. For example, 1 clinic found that checking in with patients 48 hours in advance of their appointment reduced transportation issues and no-show rates. With this advance reminder, patients had time to plan and secure transportation to the clinic. Also, providers and staff worked with various companies to obtain free or discounted services and medications.

Providing specialty care and other health services in the clinic was seen as an effective mechanism to improve access to care. In particular, dental care, language interpretation, pharmacy, laboratory tests, urgent care, and mental health services were present in clinics. For instance, 1 clinic staff member explained the value of having an integrated mental health treatment option to prevent long wait times for appointments with a specialist. In another example, 1 PD practice that came from a nurse manager was rooted in the need to get more women into the clinic for the prevention of chronic diseases that are associated with obesity. Her idea was to create a primary care practice that was strictly focused on weight management, leveraging the fact that most people experience societal pressures to be thin. “...[if] we have someone who focuses specifically on weight loss, you can get many preventative things done, too. This is a good way to bring patients in for their preventive care.” Further, this nurse also suggested wrapping mental health services around other high-interest programs such as weight loss to address underlying issues which impair adherence to self-care recommendations. Also, providing multiple services at 1 location circumvented transportation problems to another location.

In general, staff and providers exuded passion for the community they served. For some, this translated into PD practices. For example, 1 medical director considered nearly every social interaction in his professional community as an opportunity to find specialists who may be willing to provide care to his patient population.

There are not that many specialists out there that will accept our patients on a sliding scale. So as a clinical and medical director, my job is to go and find those people who have a heart for the community. So I’m in a constant search. I take every opportunity to find those people. If I’m in a social gathering or in a meeting, if I’m on the road, in the hospital, wherever I am, I try to make the contacts. (Physician)
### Ideas for clinic changes/practice reorganization

| Practice                                                                 | Description                                                                                                                                                                                                 |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Only “open access” appointments available                            | Clinic starts each day with a schedule that is completely open. Patients can call the clinic to schedule an appointment for that day.                                                                          |
| 2. “modified open access” available                                       | Clinic starts each day with a schedule that includes some open blocks of time. Patients can call the clinic to schedule an appointment for that day. The rest of the clinic schedule is filled with appointments scheduled in advance. |
| 3. “walk-in” urgent care available                                        | Clinic has a walk-in urgent care center. Patients do not need an appointment to get urgent care.                                                                                                             |
| 4. Telephone process for ascertaining patient needs                       | Clinic has health care providers who are trained to talk with patients who call to schedule appointments. Provider asks questions to figure out if patient needs same-day appointment.                        |
| 5. Reduced costs for uninsured patients                                  | Clinic charges uninsured patients on a “sliding scale,” with charges based on the patient’s income. Clinic offers payment plans that allow patients to pay for services in installments.                     |
| 6. Extended hours                                                         | Clinics offers appointment times on weekends and evenings.                                                                                                                                                   |
| 7. Appointment reminders                                                  | Clinic sends automated phone calls or text messages to remind patients about appointments.                                                                                                                   |
| 8. Policies for patients who miss scheduled appointments                 | Clinic has written policy that explains what will happen if a patient misses several appointments or more. This is to make sure that appointment times that could be used by another patient are not lost. |
| 9. Appointments with a specialist                                         | Clinic has a specific staff member who helps patients get appointments with specialty health care providers, such as a heart doctor or pain specialist.                                                    |
| 10. Group appointments                                                    | Clinic offers group appointments where patients with similar health issues come together for group care and education (patients with diabetes; pregnant women with similar due dates).          |
| 11. Personalized patient call systems                                     | Clinic makes personal phone calls to high-risk patients to help them get the care they need. For example, a clinic could call a patient with diabetes who missed an appointment and ask the patient if they are all right and discuss their condition. |
| 12. Specific staff for preventive services                               | Clinic makes it easier to get preventive care such as flu shots or immunizations. The clinic has a nurse who can order and give vaccinations without a doctor’s order.                                |
| 13. Mobile phone support                                                  | Clinic sends health-related text messages, such as appointment reminders.                                                                                                                                    |
| 14. Online access to patient medical records (patient portal)            | Clinic provides patient with Internet access (on computer, tablet, or mobile phone) to personal medical record. Patients could view laboratory results, ask for medication refills, send messages to their providers, and pay bills. |
| 15. Cost of insurance                                                    | Health care systems work on a solution for high cost of marketplace insurance.                                                                                                                                  |
| 16. Information for patients between appointments                        | Clinic sends specific information to help patients with their health needs. For example, clinics could send information about health and wellness topics, managing chronic conditions such as diabetes; using medications safely; or finding home health care supplies and services. |
| 17. Transportation                                                       | Clinic develops new ideas for helping patients get to the clinic for appointments                                                                                                                                 |
| 18. Patient education                                                    | Clinic provides educational materials that all patients can understand. For example, clinic provides materials in the various languages spoken by clinic patients.                                              |
| 19. Parent advice line                                                    | Clinic offers phone service for parents to call in and get parenting advice from clinicians.                                                                                                                    |
| 20. Health information online                                            | Clinic website has specific health information on different topics, such as health promotion, illness prevention, mental health, and managing chronic diseases.                                                               |
| 21. Health education in waiting room                                     | Trained clinic staff offer interactive or self-guided health education programs for patients.                                                                                                                   |
| 22. Community programs                                                   | Develop community-based services such as baby showers for groups of pregnant patients, free pregnancy tests, and condom giveaways at nightclubs.                                                                |
| 23. Mobile clinics                                                       | Clinic staff make visits to children at school or adults at work                                                                                                                                                |

### Ideas for patient support

| Practice                                                                 | Description                                                                                                                                                                                                 |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 14. Online access to patient medical records (patient portal)            | Clinic provides patient with Internet access (on computer, tablet, or mobile phone) to personal medical record. Patients could view laboratory results, ask for medication refills, send messages to their providers, and pay bills. |
| 15. Cost of insurance                                                    | Health care systems work on a solution for high cost of marketplace insurance.                                                                                                                                  |
| 16. Information for patients between appointments                        | Clinic sends specific information to help patients with their health needs. For example, clinics could send information about health and wellness topics, managing chronic conditions such as diabetes; using medications safely; or finding home health care supplies and services. |
| 17. Transportation                                                       | Clinic develops new ideas for helping patients get to the clinic for appointments                                                                                                                                 |
| 18. Patient education                                                    | Clinic provides educational materials that all patients can understand. For example, clinic provides materials in the various languages spoken by clinic patients.                                              |
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| 21. Health education in waiting room                                     | Trained clinic staff offer interactive or self-guided health education programs for patients.                                                                                                                   |
| 22. Community programs                                                   | Develop community-based services such as baby showers for groups of pregnant patients, free pregnancy tests, and condom giveaways at nightclubs.                                                                |
| 23. Mobile clinics                                                       | Clinic staff make visits to children at school or adults at work                                                                                                                                                |

### Ideas for new services

| Practice                                                                 | Description                                                                                                                                                                                                 |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 24. Coordinated follow-up care                                          | Clinic works with emergency departments and hospitals that might refer patients to clinic for follow-up care                                                                                               |
| 25. Community-based clinics for specific cultural groups                | Develop clinics that serve different ethnic or cultural groups. For example, community-based clinic could specialize in serving patients who are Spanish-speaking or Burmese or Amish or other. |
| 26. Disease-specific clinic                                             | Clinic sets aside specific times when they will see only patients who have a certain condition. Patients would see all of their specialty providers during the appointment. For example, the clinic could set aside specific times for patients with autism, diabetes, or issues related to women’s health. |
Table 5. (continued)

| Technology-based ideas                      | Description                                                                                                                                                                                                 |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 27. Technology specialist                   | Clinic has specific staff to train and coach other staff members on technologies. For example, technology specialists help other staff members to set up and use electronic health records, patient portals, or phone systems. |
| 28. Clinic scheduling practices             | Clinic develops better ways to schedule, so that the clinic can see more patients.                                                                                                                         |
| 29. Scheduling software                      | Clinic uses specialized software to improve scheduling.                                                                                                                                                     |
| 30. Tele-health                              | Clinic uses technology that connects patients with specialists, who may not be available at a community health center. For example, patient could have phone or video appointment with a psychologist or lactation consultant. |
| 31. Disease registry                         | Clinic keeps list of patients who have a particular condition. The clinic uses the list to try to make sure that everyone with the condition gets specific types of care.                                      |
| 32. Health information exchange              | Clinic has ability to share digital records between different health care providers and organizations.                                                                                                |
| 33. Decision support systems                 | Clinic uses software that helps health care providers improve quality of care. For example, during an appointment with a parent and child, the provider would see information on the computer about any immunizations the child needs. |

Other ideas for change

| 34. Equipment grants                        | Clinic applies for grants to buy equipment or finds sources for donated equipment. With more equipment, the clinic can complete more tests with patients during clinic visits.                              |
| 35. Creating relationships                  | Clinic focuses on building trust with at-risk patients, such as teenagers.                                                                                                                                 |

Encouraging patient accountability through active listening and education was another important PD practice. These conversations most often took place in the context of socializing patients to the process of health care delivery. One clinic administrator described her approach to patients who were frustrated from a clinic experience and how she helps them understand the complexity of delivering health care to all patients served at the clinic as well as the responsibility patients have to be partners in their own care.

... when I talk to patients I validate their issues because to everybody their issues are real... the other thing is I educate patients on “how it really needs to work” and “this is how it needs to happen.” I validate where they are, and I help them try and get to where I need them to be... I’d say I have a very good success rate of people leaving here happy with a better understanding of what the expectations are. And I think sometimes people just need to be told, you know, what part of it is your responsibility.” (Administrator)

Patient navigation has become synonymous with the notion of having individuals hired by CHCs to facilitate insurance enrollment under the Affordable Care Act and offers another example of the importance of socializing patients to the health care delivery process. Notably, 1 patient navigator discovered that many patients getting insurance coverage for the first time were not aware of preventive care available at no cost, so she assembled an educational brochure explaining the services.

The preventive services that you get wasn’t really advertised... No matter what your deductible is or your premium, it’s covered for free. So I made 1 [brochure] for adults, 1 for women, and 1 for children. So now when people sign up for coverage, I can give them one of those.” (Patient Navigator)

Positive Deviance Practices to Improve Patient Experience

Multiple factors can contribute to a negative care experience. The most commonly mentioned contributors to a negative experience included prolonged waiting time until available appointment, poor customer service (either on the phone or in the clinic), disorganized care, lack of empathy, short amount of time with the provider, long wait time on the phone, and high turnover in clinical staff.

Multiple comments suggested the remedy for improving patient experience was grounded in positive interpersonal relationships and building a culture of customer service and patient-centeredness. We most often heard about positive practices which built rapport with patients by actively listening and communicating in a respectful and collegial manner. One patient explained the value of “that personal touch, you know, it was a friendship there, you know, not just as a doctor. I always felt that he cared about my sons...” Numerous patients noted the rapport and engagement generated when clinic staff knows their name; others talked about the security of seeing providers and staff who have been in the clinic for years. One mother discussed a time when she brought her son in for help with mental health challenges.

One of the nurses has known him since he was born, and she is still there. And that was the first face he saw when he walked down the hallway... He felt at ease, you know. So, I have those long-term relationships...” (Mother of Adolescent Patient)

Both patients and staff agreed that enhancing communication, creating effective interpersonal relationships, and treating patients with respect were key components to developing...
Rapport with patients and an effective organizational culture. One physician explained the approach to adolescent patients, a population difficult to reach.

We are somewhat aggressive in talking directly to teenagers and kicking parents out of the room because they don’t need to be involved in parts of the conversation. I had some of them tell me “we like talking to you ‘cause you’re real and you talk to me.” (Physician)

Other staff explained the value of positive patient–provider communication to encourage appropriate access—“be encouraging, be uplifting, be supportive but, for lack of a better expression, keep it real.”

The architectural design, physical appearance of the clinic, and its amenities and services also contributed to positive patient experiences. Patients expressed a desire for a clean, open-design and comfortable environment with a play area for children. One patient told us that she scouted out the clinic before scheduling an appointment, “I just acted like I had to use the bathroom and I could like check it out and see if everything was up to par. I came in here and it was like, oh, yeah, they’re clean and everything.”

Other contributors included specific actions, services, or policies that had been established. For example, creating tailored education to facilitate diabetes self-care or group visits and incentive programs aimed at improving adherence to recommended prenatal visits. Other factors such as easy appointment scheduling, limited paperwork, clinic proximity to home, and short waiting time were also valued. Patients also appreciated surveys and/or follow-up phone calls to identify, address, and resolve patient concerns. For convenience, patients preferred to have laboratory tests, radiologic scans, and other procedures, all offered on-site at the clinic.

Notably, some clinics had hired dedicated staff focused on serving the homeless population in the community. There were several PD approaches to improve access for homeless patients, including working to accommodate homeless patient schedules that revolve around temporary part-time work, meal availability at shelters, and case management meetings.

At 1 site, homeless outreach personnel brought care directly to patients in their living environment, “If I take the flu shots over to the [homeless shelter] I have a much better turnout rate than if I just say, “Hey I’m doing a walk-in. Why don’t you guys come over [to the clinic].” This individual also kept a ready supply of needed items that she could give patients when they came for an office visit, I always find that they need things. So I have things here like toothbrushes, toothpaste, floss, personal hygiene items, pads, ChapStick, eye drops, first aid kits with triple antibiotic ointment, and Band-Aids that they’re able to take.” (Homeless Outreach Coordinator)

There were numerous no-cost/low-cost practices that shared 2 characteristics: process and communication. For example, in every clinic, there existed frustration around the phone system. Breakdowns in appointment scheduling, patient–clinic relationships, and clinic efficiencies could all be tied back to the phone system. Although in some cases the phone systems themselves simply needed to be replaced, more often the issue had been resolved with improved process and communication. One clinic manager we encountered had trained her front office and scheduling staff to handle phone interactions as if patients were hotel guests, mandating a commitment to customer service. More important than the idea of customer service itself was the process put in place and communication of this goal to all staff. Similarly, establishing no-show policies, enforcing them, and communicating expectations to patients was an effective means established by the clinic chief medical officer (CMO) to foster accountability in patients. Equally important to the innovative policy was the creation of a mutually respectful platform for discourse between patients and staff.

Discussion

Although numerous studies have examined the needs of underserved patients and improved access to health care,7,18–25 our approach to understanding this problem is unique. First, we applied a PD approach6 to identify individuals who were known to have uncommon approaches to either obtaining health care (patient perspective) or delivering care effectively (clinic staff perspective). This approach gave us an opportunity to focus our findings on unique strategies that complement existing challenges to accessing health care. Across strategies to improve health care access in CHCs (practice reorganization, patient support, and new services7), patient centeredness and customer service consistently motivated trialing new practices and seeking process and care delivery improvements. Moreover, similar to other findings, these emergent strategies for improving health care access reinforce that nonfinancial barriers (e.g., acceptability, accessibility, accommodation, and availability25) are critical for improving health care access.18–20 For example, our participants agreed that successfully gaining access to care was dependent on people understanding on how to navigate the health care delivery system (accessibility) as well as being aware of the expectations of them as patients (acceptability). While financial barriers (affordability24) were discussed by many participants as an important obstacle to overcome, we found this to be reported along with nonfinancial barriers to accessing health care.19,20 For example, limited transportation options to pick up medications or attend an office visit present an accessibility barrier that is inextricably linked to affordability of obtaining care and adhering to medical recommendations.26

Although the present study included a general underserved population seeking care at CHCs, other research has targeted health care delivery issues for specific populations (e.g., elderly people, immigrants). Taken together, findings suggest that consideration for social determinants of health are vital for improving health care access. Batista and colleagues22 suggest that, for immigrants, social programs that facilitate social networks and integration into a community can encompass health care access and understanding health care delivery options. Likewise, clinics’ ability to provide interpreter services and
cultural sensitivity is responsive to cultural barriers affecting health care access. For elderly, rural populations, Ford and colleagues’ literature review suggests that ease of scheduling an appointment, navigating health care systems, and comfort in a clinic can impact the decision to seek care for persistent physical symptoms. In response to these contextual factors, clinics need efficient scheduling practices, referral programs when specialty care is required, and sufficient allotted time with providers. These recommendations are consistent with strategies employed by participants in this study to improve the patient experience. Creating a culture of customer service and patient centeredness was a prominent PD approach, including meeting patients where they are for care delivery (e.g., homeless patients), explicitly making patients feel welcome, and personalized reminders.

In addition to addressing health care access, clinics must ensure that health care delivery includes a range of health services, from prevention to managing chronic conditions. As Comino and colleagues report, effective strategies for prevention and chronic disease management diverge somewhat. For diabetes, a chronic condition, consistent monitoring improved diabetes management; effective interventions targeting this outcome included practice reorganization, workforce development, and financial incentives. Similarly, as a practice reorganization strategy in the present study, clinics offered patients with diabetes bundled appointments with a provider (glucose monitoring), dietician, and health educator during 1 clinic visit. Also in Comino and colleagues’ review, the number of patients receiving a preventive service was improved by ensuring patients showed up to appointments; effective interventions to improve patient attendance included patient support/education and appointment reminders (practice reorganization effort). Likewise, in the present study, at 1 clinic, providers (physician, medical technician, nurse, and behavioral health specialist) worked as a team with a patient consistently, which over time facilitated relationship building and patient support. Additionally, automated reminder systems and reminder calls were used at several clinics to increase patient attendance.

Limitations of the Study

Our study findings are limited by the purposeful sampling method used to recruit participants and the challenges experienced in finding PD interview participants. Although we asked clinic managers to recruit patients who routinely came to their office appointments and had overcome some major obstacles in life, and to invite clinic staff who were passionate about their work and took unique approaches, not all of the participants we interviewed could be considered as positive deviants. Ideally, we would have used objective data to select those who had been more successful in regularly improving access. Unfortunately, most clinics found this level of analytics capability infrequently available. However, by simply using a PD lens to understand and look for promising novel approaches to problems inspired discourse during our interviews. For example, 1 question that we used in every interview was “...if you had a magic wand and could change anything about the clinic, what would it be?” The interviewer would further probe participants to consider possible changes without constraints of practicality and logistics. In this question, the true PD thinking often emerged. Also, a semi-structured interview approach was appropriate to understand details of strategies that exist in a complex work environment such as a clinic. However, future research could employ other methods to further understand strategies to improve health care access. Focus groups could recruit patients from specific subpopulations or with particular medical conditions to uncover targeted strategies to improve access or health care delivery for these individuals; alternatively, a large-scale survey on access strategies and customer service could be used to gather opinions and beliefs across a wider range of individuals.

Implications for Policy or Practice

Based on these findings, several practice implications for CHCs emerge. First, there are opportunities to improve patient experience in clinics by setting expectations for accountability in their own care and providing an enhanced feeling of customer service. For example, staff can help patients understand the trickle-down effect on access to care when they miss or cancel an appointment. Likewise, to encourage a customer service orientation when interacting with patients, staff can be trained to manage care delivery delays or difficulties and support patients emotionally. Creating a more effective patient no-show/cancellation policy is one strategy to ensure that available appointment slots are not wasted. Finally, this study is a demonstration of applying a PD approach and offering a novel look into this process.

Conclusion

We uncovered many practical approaches to improving access to care for underserved populations by listening to patients, clinical staff, and providers who have found creative pathways through the health care system. Specifically, we found that a patient-centered approach to specific challenges—including poor health literacy, providing tailored support to overcome the social determinants of health and integrated care services (e.g., mental health, dental care)—to be the pathway of the positive deviants in our study. Additionally, delivering a good patient experience (e.g., positive interpersonal relationships, feeling known, being encouraged, and a clean clinic environment) was a prominent strategy among patients who were successful at gaining access to care and clinics that were able to reach difficult populations. Compassion is fundamental: among both clinic staff/providers with a heart for the clinic mission and patients taking a cooperative stance in their own care.

Acknowledgments

The authors thank Ayten Turkcan, Amy Olson Miller, Iman Mohammadi, and patients/staff of participating community health centers.
Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported through a Patient-Centered Outcomes Research Institute (PCORI) Award (IH-12-11-5488).

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