Organizational Climate and Physician Office Staff: A Grounded Theory Study of Patients' Perspectives of Staff Stress and the Influence on Personal Health Behaviors

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Abstract

Healthcare in the US has been in an extended state of accelerated change since the passing of the Affordable Care Act in 2010. Sweeping policies designed to reduce cost per capita, improve the patient experience of care (including quality and satisfaction), and improve the health of populations are being implemented at the macro and micro levels of healthcare services. Chronic illness is a leading factor in the rising costs of healthcare. This issue is driving more patient care from the hospital to the outpatient setting, such as physician practices, to reduce costs. Additionally, this paradigm shift is transitioning the patient from one of consumer of services to a co-manager of their own health. Managing chronic illness is a team endeavor with multiple healthcare players and support staff in concert with the patient. The ensuing relationship is a key element of success to the goal of living well. This qualitative constructivist grounded theory study of 11 patients with chronic illness explains their perceptions of organizational climate in physician office practices and conceptualizes perspectives of developing the patient-staff relationship. The major thematic construct is a model which demonstrates how chronically ill patients' perceive the significance of the patient-staff relationship as proxy to their physicians. This emerging model informs healthcare leaders and practitioners how organizational climate influences patients' perceptions and their health behaviors, and the significance placed on their patient-staff relationships.

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Dedication

This dissertation is dedicated to all the intelligent, compassionate and highly committed women and men on the front lines providing safe, high-quality patient care. You are my heroes.

This work is produced with deep appreciation for the professors at St. John Fisher College. To Dr. Robinson, your patience and support during the admission process endured throughout this journey. Early on you said to me, "You have a powerhouse committee." I had little understanding of the depth of that statement, however, I kept repeating this to people I know. Someone asked me, "what does that mean?" I could not respond then but have clarity now.

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"I took a walk in the woods and came out taller than the trees." Thoreau

Biographical Sketch

Nancy Daoust is an executive healthcare leader currently the chief ambulatory officer at Upstate Medical University in Syracuse, NY. Ms. Daoust is a fellow in the American College of Healthcare Executives, a graduate of the ACHE Executive Program and serves as president of the central New York Chapter, HCMACNY. Daoust is a licensed NYS nursing home administrator and holds an AAS Medical Assistant from SUNY Alfred, BS Healthcare Administration, Magna Cum Laude, SUNY Brockport, and MS Management, Keuka College. Daoust came to St. John Fisher College in the summer of 2017 and began doctoral studies in the Ed.D. Program in Executive Leadership. Daoust pursued her research in patients' perspectives of organizational climate of physician office staff under the direction of Dr. Theresa Pulos and Dr. Anastasia Urtz and received the Ed.D. degree in 2019.

Abstract

Healthcare in the US has been in an extended state of accelerated change since the passing of the Affordable Care Act in 2010. Sweeping policies designed to reduce cost per capita, improve the patient experience of care (including quality and satisfaction), and improve the health of populations are being implemented at the macro and micro levels of healthcare services.

Chronic illness is a leading factor in the rising costs of healthcare. This issue is driving more patient care from the hospital to the outpatient setting, such as physician practices, to reduce costs. Additionally, this paradigm shift is transitioning the patient from one of consumer of services to a co-manager of their own health. Managing chronic illness is a team endeavor with multiple healthcare players and support staff in concert with the patient. The ensuing relationship is a key element of success to the goal of living well.

This qualitative constructivist grounded theory study of 11 patients with chronic illness explains their perceptions of organizational climate in physician office practices and conceptualizes perspectives of developing the patient-staff relationship. The major thematic construct is a model which demonstrates how chronically ill patients' perceive the significance of the patient-staff relationship as proxy to their physicians. This emerging model informs healthcare leaders and practitioners how organizational climate influences patients' perceptions and their health behaviors, and the significance placed on their patient-staff relationships.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

The rapid changes underway in healthcare are placing stress on outpatient physician office practices (Schwartz, 2012). The Affordable Care Act (ACA) of 2010 shifted patient care from the high-cost hospital setting to the lower cost outpatient setting such as physicians' offices (Chokshi, Rugge, & Shah, 2014). Concurrently, the World Health Organization (2014) stated chronic disease is the leading cause of death, accounting for 60% of deaths worldwide. The Centers for Disease Control and Prevention (CDC, 2014) declared chronic diseases such as diabetes, heart disease, and arthritis account for three of every four dollars spent on health care in the United States. Additionally, 86% of healthcare spending is for patients with one or more chronic conditions (Department of Health & Human Services, 2014). To reduce costs, ACA policies have transitioned patients managing chronic disease to physicians' offices. This trend is creating new dynamics and challenges in this environment.

Physician office practices are supported by clinical and administrative staff who interact to provide patient care. Physicians, staff, and patient interactions influence the office environment. Groups of interrelated experiences and meanings people share at work create an organizational climate (OC) (Schneider, Ehrhart, & Macey, 2013). Primarily, the research of OC has been conducted by employee surveys focused on phenomena people experience in the workplace (Schneider, Gonzalez-Roma, Ostroff, & West, 2016). Stressful healthcare climates assessed by staff feedback measuring emotional exhaustion, role conflict, and role overload are characterized by employee

perceptions that they are emotionally exhausted and unable to get things done (Glisson et al., 2008).

Perez (2017) suggests chaotic practices are associated with adverse work conditions, dissatisfied physicians, and medical errors. A secondary data analysis of Minimizing Error, Maximizing Outcomes (MEMO) Study of 112 national primary care practices assessed which characteristics define an unhealthy medical practice or workplace (Perez, 2017).

Four data sources of physician surveys, practice manager organizational assessments, patient surveys, and medical record audits were analyzed in this cross-sectional design. The primary variable for physicians surveyed was perception of the atmosphere of the office environment from 1 = calm to 5 = chaotic. The managers' organizational assessment gathered practice payer type data, patient demographics, and bottlenecks to patient flow (11 items rated from 1 = little or no extent to 4 = large extent). Patients were surveyed for socioeconomic characteristics. Medical record audits were conducted over 18 months by trained researchers to review quality of care standards and medical errors (Perez, 2017).

Practices with physician ratings of atmosphere equaling 4 or 5 (1-5 Likert scale) were classified as "chaotic." Regression models were performed to compare characteristics of chaotic versus nonchaotic with chaos as the independent variable (IV). Additional regression models were performed of physicians within practices with chaos as IV and patient outcomes were the dependent variables. Models were controlled for patient demographics (Perez, 2017). The results demonstrated that 35.7% of practices were rated as chaotic by at least half of their physicians with a mean chaos rating of 3.48.

Practices' managers at chaotic offices reported greater bottlenecks in patient flow, phone access, and retrieving patient charts. Perez (2017) concludes that chaotic practices showed greater errors and missed prevention opportunities.

Additional research endorses an association that aspects of OC influence better chronic disease processes and patient management in the physician office practice (Benzer et al., 2016; Husdal et al., 2018; Vargas Bustamante, Martinez, Chen, & Rodriguez, 2017). Benzer et al. (2011) hypothesized that two dimensions of OC; relational and task climate, are positively associated with chronic care management in the primary care setting. Relational climate is described as leadership by promoting trust and supportive collaborations among staff and fostering positive interactions among staff. Task climate refers to a management focus on achievement and improvement (Benzer et al., 2011).

This observational, cross-sectional study provides partial support for a relationship between relational climate and clinic effectiveness. Benzer et al. (2011) found relational climate was positively related to increased likelihood of patients receiving foot care. No significant findings for task climate related to patients receiving foot care were noted. Benzer et al. (2011) recommends further research to investigate the influence of OC in practice settings for other chronic conditions. Most of the literature related to OC in physicians' practices is devoted to internal organizational processes, efficiency, quality, physician, and staff satisfaction.

Problem Statement

Patients' perceptions and judgments of physician wellness may influence their feelings of trust and comfort, as well as their health behaviors (Kowalski et al., 2009;

Lemaire, Ewashina, Polacheck, Dixit, & Yiu, 2018). The patient-physician relationship

or working alliance has been shown to be closely associated with patients' adherence to

treatment (Fuertes, 2007). A working alliance creates a partnership which facilitates trust

and communication enhancing the patients' ability to understand the value of and greater

ability to be compliant with treatment (Fuertes, 2007). Vries et al. (2014) argue that

physician fatigue and stress account for poor patient-clinician communication influencing

patient outcomes in oncology.

In addition, Lemaire et al. (2018) suggest that when patients perceive staff to be

busy or overworked, they remember less information from the office visit. Neumann et

al. (2007) note that cancer patients' perceptions of the general busyness of hospital staff

had a strong negative influence of patients' reported physician empathy. Further, this

phenomenon indirectly influenced the patients' desire to obtain additional information

about their health findings and treatment options. The research on OC in the healthcare

setting supports an influence on both staff and physician behaviors as well as patient

outcomes (Benzer et al., 2016; Vargas Bustamante et al., 2017).

Chronic disease is the leading cause of mortality in the world (Stenberg &

Furness, 2017) and the highest contributor to healthcare spending (Department of Health

& Human Services, 2014). As a result, policy makers are redefining the role of patients

from consumers to co-producers of their care (Coulter & Ellins, 2009). Stenberg and

Furness (2017) theorize a grounded theory conceptual model that living well with a

chronic disease encompasses the role of patient self-care. Physicians and office staff

perform a central role in educating patients about how to manage aspects of chronic

disease. What is less understood is how patients' health behaviors are influenced by their

perceptions of OC of staff in the physician office-based setting.   Therefore, this study

utilized a qualitative analysis to assess this phenomenon from a different lens, the

patients' perspective. The intent of this study is to develop a deeper understanding of

how complex factors surrounding organizational context, systems, and actors influence

the patients' perspectives.

Theoretical Rationale

Given the research topic of whether patient health behavior is influenced by

perceptions of office staff, several behavioral theoretical models were evaluated as the

framework to support this study. Potential theoretical approaches of behavior models and

patient adherence were assessed. Some theory models have one or more components

which are applicable in this study context. However, none of the models account for the

complex nature of this phenomenon from the patient perspective; therefore, to address the

rich and dynamic environmental context, grounded theory methodology is indicated.

This theoretical rationale explains the logic used to determine the approach to construct a

theoretical model.

Ajzen and Fishbein's (1975) theory of reasoned action (TRA) models how any

behavior under volition or will is produced by beliefs, attitudes, and intentions about that

behavior (Hankins, French, & Horne, 2000), as shown in Figure 1.1. The theory supports

a person's behavior as a function of the individual's behavioral intention, which is

determined by attitude toward the act and beliefs about what others' expectations are, or

subjective norms. Ajzen and Fishbein's theory represents tenets of personal behavior;

however, the theory is predicated on behaviors produced under volition.

Figure 1.1 Theory of reasoned action
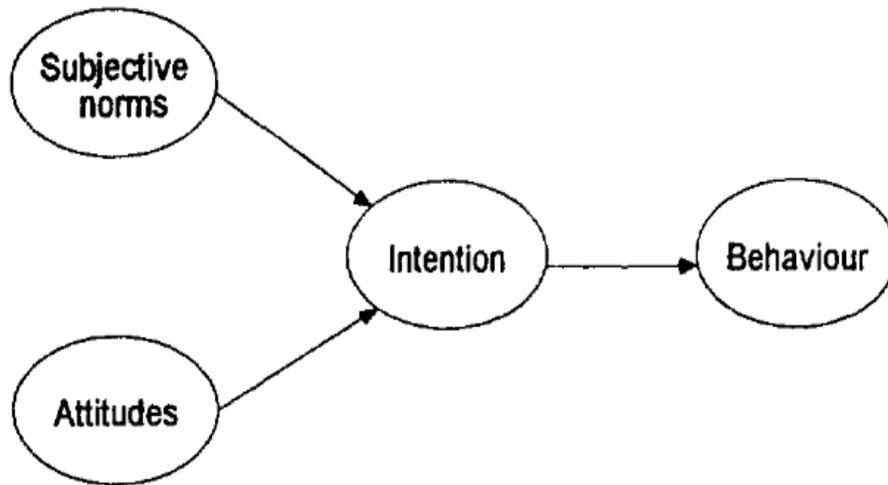
Figure 1.1. Reprinted from Hankins, M., French, D., & Horne, R., (2000). Statistical guidelines for studies of the theory of reasoned action and the theory of planned behavior. *Psychology and Health, 15,* 151-161

Ajzen later examined an extension of TRA to provide a model suggesting how all

behaviors are produced, not just those under volition (Hankins et al., 2000). This

extension concept included the perceived ease or difficulty of performing a behavior or

perceived behavioral control. The distinction of perceived behavioral control is not just

as a third determinant influencing intention, but also suggests that behavior can be

influenced directly by an individual's actual degree of control over the behavior, as noted

in Figure 1.2. The theory of planned behavior (TPB) developed by Ajzen's research

describes how personal attitudes, subjective norms, and perceived control over the

behavior interact to influence intentions and, consequently, the behavior itself (Gulliver,

Griffiths, Christensen, & Brewer, 2012). Hankins et al. (2000) confirms the theory has

generated extensive empirical validation of the model.

Figure 1.2 Theory of planned behavior
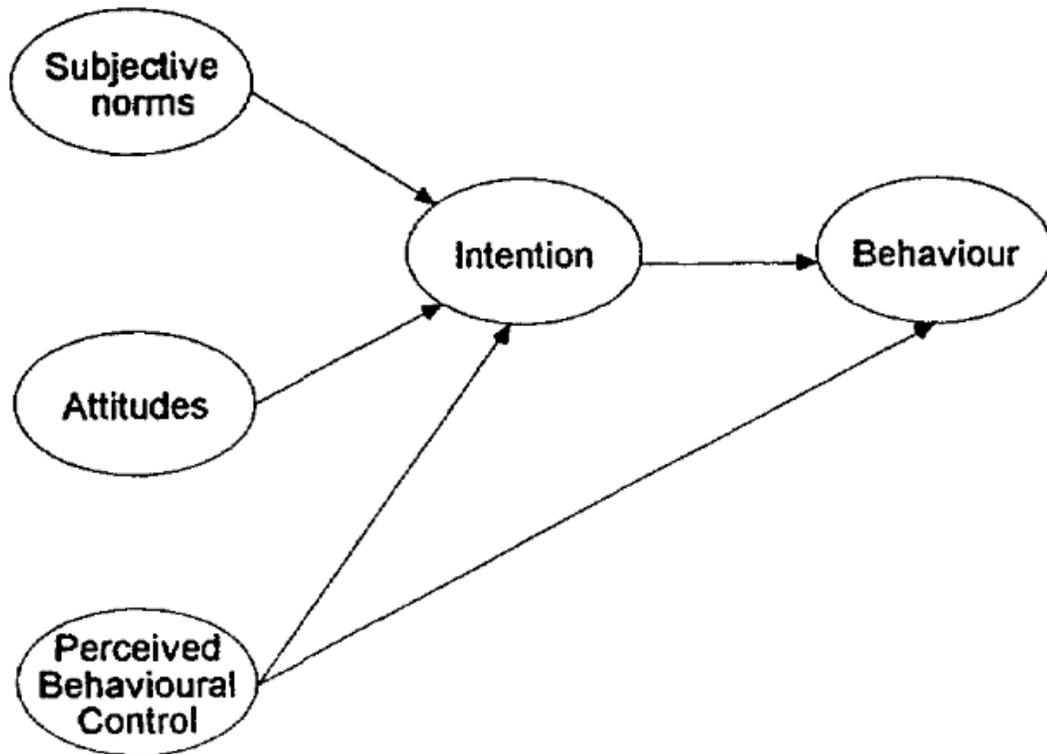
Figure 1.2. Reprinted from Hankins, M., French, D., & Horne, R., (2000). Statistical guidelines for studies of the theory of reasoned action and the theory of planned behavior. *Psychology and Health, 15,* 151-161

  Rich, Brandes, Mullan, and Hagger's (2015) meta-analysis reviewed TPB for predicting adherence with those of chronic disease. The findings show the effect size between intention-behavior in this analysis as ($r+ = 0.28$) referencing a frequently found gap. The authors posit the gap as a validity threat to TPB, whereby interventions targeted to enhance behavioral acceptance and adherence do not always result in desired health behavioral changes. While their analysis strongly supports TPB across many health behaviors, it also suggests that the validity for adherence prediction is limited in people with chronic illness. Rich et al.'s (2015) meta-analysis of TPB suggests the model for

predicting patient adherence to treatment in chronic illness is limited. Given the extended

nature of chronic illness, adherence to treatment is a behavior that needs to be carried out

long-term. McEachan, Conner, Taylor, and Lawton (2011) endorse moderations to

relations among the TPB variables with the intention-behavior relationship being weaker

in studies with longer follow up periods. Thus, Rich (2015) found that the prediction of

behavior would be lessened given the long-term nature of chronic illness.

Additional theories reviewed for applicability include Rosenstock's health belief

model, based on the construct of individual perceived benefits and perceived barriers; is

indicated as a consistently strong predictor of health behavior (Janz & Becker, 1984).

Hall and Fong's (2007) temporal self-regulation theory describes the strength of

connectedness between present actions and anticipated outcomes with values attached to

anticipated outcomes. Both theories incorporate the construct of ecological context.

Ecological context refers to the environmental structures which facilitate or reduce risky

behavioral tendencies (Hall & Fong, 2007). While both theories are more contemporary

models of health behavior, neither possesses the components related to the dynamics or

influence of healthcare workers' interactions with patients.

Social-cognitive models have been studied in the broad context of health

behaviors. The interaction model of client health behavior emphasizes the process which

physician and patient together determine a health decision and health action (Cox, 1982).

This is a nursing construct which places emphasis on the process by which the singular

position of each client is translated into health behaviors. The model focuses on patients'

internalization of responsibility for positive health behaviors. This model places the

healthcare worker in the teacher or counselor position and the patients' control is

dominant. Cox (1982) describes this model as comprehensive and complex, which makes it more difficult to work with and reduces the appeal inherent in simpler theoretical constructs.

Patient adherence, defined as the extent to which patients follow treatment or health behaviors recommended by their doctor, is a key aspect of patient behavior (Dimatteo, Haskard-Zolnierek, & Martin, 2012). Brandes and Mullen (2014) argue the common sense model (CSM), which proposes that patients are active problem solvers and they create mental representations of disease to make sense of it. This mental representation, which influences coping behaviors and outcome expectations, is not a strong predictive model of adherence (Brandes & Mullen, 2014). Therefore, while several behavioral theories—including those specific to health behaviors—incorporate many determinants which influence patients' health behaviors, individually, they do not present enough applicability for this study. And so, grounded theory methodology is used because the process is systematic, yet it includes flexible guidelines for qualitative data collection and analysis to construct theory (Charmaz, 2014). The grounded theory approach allows for exploration and explanation of social processes in human interactions (Ebrahimi, Sadeghian, Seyedfatemi & Mohammadi, 2017). Additionally, this methodology is utilized to study assumptions and concepts which are not yet fully identified (Streubert & Carpenter, 2010).

Statement of Purpose

The purpose of this study is to gain an understanding of the patients' perceptions of physician office staff stress experienced while in the medical office. Specifically, the

influence of this experience on the patients' health behaviors will be studied so that the following questions will be evaluated.

Research Questions

Therefore, the research questions are:

R1: What are the patients' perceptions of physician office staff stress?

R2: How do the patients' perceptions of physician office staff stress influence patients' health seeking behaviors?

Potential Significance of the Study

This study has the potential to contribute to the research regarding OC in health care settings, specifically physicians' office practices, which suggest organizational factors influence healthcare workers' ability to provide patient care supporting patient outcomes. There is an abundance of literature which supports OC factors within the healthcare environment influencing staff stress (Bronkhorst, Tummers, Steijn, & Vijverberg, 2015; Carlucci & Schiuma, 2014; Karantzas et al., 2016; MacDavitt, Chou, & Stone, 2007). Additional research argues that factors of OC influence managing patients with chronic disease and implementing practice change to improve chronic care models (Benzer et al., 2016; Dickinson et al., 2015; Kadu & Stolee, 2015). Other research proposes factors of OC influence on outcomes for patients with diabetes (Vargas Bustamante et al., 2017).

There is research supporting factors of OC influence on patients' perceptions of healthcare environment with patients' outcomes (Braithwaite, 2016); however, there is very limited study which has identified any influence of patients' perceptions of physician office staff OC with their own health seeking behaviors. The exploration of a

10

theory of such influence could add to the understanding of the patients' experience and subsequent patients' behaviors, which are not currently identified or understood.

Definitions of Terms

Organizational Culture:

Organizational culture is the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (Schein, 1984, p. 3).

It is referred to as the shared values of an organization (Reddy, Shea, Canamucio, & Werner, 2015).

Organizational Climate: "Organizational climate refers to a set of attributes which can be perceived about a particular organization and/or its subsystems, and that may be induced from the way that organization and/or its subsystems deal with their members and environment" (Hellriegel & Slocum, 1974, p. 256). Schneider, Ehrhart, and Macey (2013) define organizational climate as groups of interrelated experiences and meanings people share at work. This is considered a subset of organizational culture.

Chaotic Practices/Unhealthy Medical Practice: Chaotic practices/unhealthy practices and organizational chaos is defined as poor organization and coordination of the labor processes (Einarsen et al., 2003). Linzer (2009) notes chaotic practice as the office pace of the workflow.

Voice Climate: Voice climate is defined as discretionary communication of ideas on work issues with intent to improve or enhance operational or organizational functioning (Morrison, Wheeler-Smith, & Kamdar, 2011).

Relational Climate: Relational climate is described as leadership by promoting trust and supportive collaborations among staff and fostering positive interactions among staff (Alderfer, 1972).

Patient Adherence: Adherence refers to the ability or willingness to stick to or follow a healthcare plan at the request of a healthcare expert (Dunbar, 1980).

Patient Health Behavior: Patient health behavior, as defined by the health belief model, is determined by perceptions of susceptibility to and the severity of a health threat (Rosenstock, 1974).

Self-Efficacy: Self-efficacy expectation is the conviction that one can successfully execute the behavior required to produce the outcomes (Bandura, 1977).

Chapter Summary

Stressful healthcare environments are characterized by employee perceptions of being emotionally exhausted and unable to get things done (Glisson et al., 2008). Schwartz (2012) suggests the rapid changes underway in healthcare are placing stress on outpatient physician office practices where staff and patients have daily encounters with one another. This environment presents as a complex arena of systems, actors, policies, and processes which contribute to the OC.

If the environment where this relationship occurs is stressful or perceived as chaotic, how might this influence the patient's perception of these interactions? The patient living with chronic illness is in a long-term partnership with the physician and

supporting healthcare team. This partnership is intended to help facilitate trust and communication to enhance the patient's ability to understand and adhere to recommended treatment.

There is abundant literature which analyzes OC in healthcare services. Several studies (Bahrami, Barati, Ghoroghchian, Montazer-alfaraj, & Ezzatabadi, 2006; Bronkhorst et al., 2015; Carlucci & Schiuma, 2014; MacDavitt et al., 2007) support the influence of OC on nursing performance and outcomes. Additionally, the influence of OC related to physician stress, productivity, and performance is well supported in literature (Benzer et al., 2016; Mohr, Benzer, & Young, 2013; Perez et al., 2017; Vargas Bustamante et al., 2017).

This study offers an approach using grounded theory methodology designed to focus on the patient perspective in this context and to understand how OC influences their perceptions and health behaviors. This dissertation content is presented in the prescribed chapter format. Chapter 2 literature review will provide further synthesis of the developing research about OC in healthcare service environments. Key literature content areas include OC and environment and employee stress, OC and patient outcomes, and OC in relation to managing chronic illness. Chapter 3 outlines the grounded theory research design methodology and provides the framework of the research participants, data collection tools and data analysis processes. Constant comparative method is utilized in coding analysis and memoing to enhance theory development. Chapter 4 shall present the research study questions answered by the data findings and presented by thematic categories, concepts and related dimensions and properties. Finally, Chapter 5 will pose the study implications of findings, discuss limitations and provide

recommendations for future study considerations. A concluding summary of the full

dissertation will synopsize the work in its entirety.

Chapter 2: Review of the Literature

Introduction and Purpose

The literature of organizational climate (OC) appeared in the 1970s to begin to conceptualize, measure, and utilize the construct (Hellriegel & Slocum, 1974). The research is prevalent across multiple business sectors (Harter, Schmidt, & Hayes, 2002). The confirming relationship between employee satisfaction and business outcomes is evidenced in Harter et al.'s (2002) meta-analysis of nearly 200,000 respondents from 7,939 business units across 36 companies. This meta-analysis showed generalizability of overall employee satisfaction and engagement correlates with customer satisfaction and loyalty, organization profitability, productivity, employee turnover, and safety outcomes.

This analysis included organizations of finance, manufacturing, retail, service (including health), transportation, and public utilities. The strongest effect sizes of overall satisfaction and employee engagement were employee turnover, customer satisfaction/loyalty, and safety. Overall satisfaction and employee engagement true score correlations (*ps*) were highest for customer satisfaction with loyalty (.32 and .33) employee turnover (-.36 and -.30), safety (-.20 and -.32), productivity (.20 and .25), and profitability (.15 and .17). This meta-analysis provides empirical support that employee satisfaction and engagement correlates to meaningful organizational outcomes (Harter et al., 2002). These generalizable findings apply across multiple business sectors.

This review of literature will synthesize research on OC and its influence on employee satisfaction and engagement in the context of healthcare services. The main

themes of OC addressed in the literature review are; OC influence on the healthcare work environment and employee stress, OC influence on managing chronic illness, and OC influence on patient perception and outcomes.

Organizational Climate Influence on the Healthcare Working Environment and Employee Stress

OC research in healthcare services provides parallel arguments to the Harter et al., (2002) meta-analysis. Bahrami et al. (2016) examined the relationship of OC and employee satisfaction (ES) to organizational commitment among hospital RNs in a quantitative, descriptive, cross-sectional study. The correlation of organizational commitment and OC ($r = 0.269$, $p = 0.01$) and the OC variable of avoidance or aloofness of OC showed a positive relationship to affective commitment ($r = 0.208$, $p = 0.049$), which is described as staff emotional attachment to and involvement in the organization. Healthcare (HC) workers with strong affective commitment chose to stay with an organization because they wanted to (Bahrami et al., 2016).

OC is relevant to knowledge-intensive service industries where creating value is critical (Carlucci & Schiuma, 2014). Carlucci and Schiuma (2014) observed how HC workers perceived awareness of OC as environmental context and its relevance in driving exceptional performance. This study utilized an action research mixed methods design because OC is strongly affected by context; thus, research addressing this phenomenon should account for organizational context (Carlucci & Schiuma, 2014). Staff perceived that factors of OC intuitively influenced service quality, ability to satisfy patients, productivity, and innovation. These factors included motivation as related to performance reward systems, knowledge of strategic objectives, teamwork, and conflict

resolution. This understanding informs leadership to ensure that HC workers understand how and why initiatives are implemented to improve value and service, and that HC workers should be engaged for input into those initiatives. OC can function as a lever to improve both HC workers and organizational performance.

The relationship between OC and HC workers' performance and well-being is well documented. MacDavitt et al. (2007) systematic review demonstrates that OC influences nurse well-being outcomes. Several OC domains assessed included leadership, work design (scheduling, autonomy), group behavior, quality emphasis, and outcomes for HC workers. Nurse outcomes measured included job turnover, blood and body fluid exposure, occupational injury, job satisfaction, and burnout and/or stress. Sub-domains of nurse perceived staffing levels, collaboration, and communications positively influenced nurse retention, occupational injuries, and burnout. Additionally, MacDavitt et al. (2007) found an inverse relationship between positive perceptions of safety climate and hazardous exposure, and a positive relationship between employee satisfaction and perceived leader support, staffing, and autonomy.

Karantzas et al.'s (2016) cross-sectional study further developed the relationship of OC variables, specifically organizational pressure, autonomy, support, and trust with HC staff self-efficacy, defined as the belief in one's ability to perform tasks. HC workers' perceptions of higher autonomy, support, and trust were positively associated with self-efficacy. Self-efficacy was found to mediate the OC factors and the HC workers' strain of providing care in a chronic care setting, which was caring for residents with dementia in this study.

Expanding on the concept of HC workers' stress, in a systematic review of OC

and employee mental health outcomes, Bronkhorst, Tummers, Steijn, and Vijverberg

(2015) focused on how OC relates to employee mental health in healthcare and which

dimension of OC is most strongly related to employee mental health. Bronkhorst et al.

(2015) characterized three OC dimensions: leadership and supervision, group behavior

and relationships, and communication and participation. Employee mental health was

broadly assessed to include psychological disease (burnout, depression, and anxiety), in

addition to general mental health and psychological distress.

Bronkhorst et al.'s (2015) research captured two models: one suggests OC (work

relationships, respect, involvement) as a stressor directly influencing HC workers' mental

health; the other models OC (job design and future, psychological work adjustment) as an

indirect influence of employees' perceptions that can be negative or positive. Peer-

reviewed, quantitative design studies published from 2000 to 2012 were narrowed to 21

and assessed for quality, with a total mean score (7.8, 0-14 scale).

The aggregated results suggest that OC dimensions of strong leadership and

supervision, support significantly lower outcomes of HC workers' poor mental health.

Overall, 17 out of 29 (59%) leadership dimensions (supervisory support, trust in leader,

fairness of leader) were reported as statistically significant, and 12 (41%) as

nonsignificant. The overall findings support that good employees' perceptions of OC

(alignment and trust in leadership, coworker support, team collaboration) positively

influence HC workers' mental health (Bronkhorst et al., 2015).

Bronkhorst et al. (2015) additionally suggest OC dimensions of group

relationships consistently showed that coworker social support has significant effects on

employee mental health. Aggregated results indicated favorable group behavior positively relates to mental health among HC workers. Of the 26 relationships tested, 19 (73%) were statistically significant. Strong leadership and positive group behaviors demonstrated a positive effect on HC workers' mental health factors of burnout, emotional exhaustion, depression, and general mental health.

Leadership and supervision present as OC factors in the literature as evidenced by Bronkhorst et al. (2015), as well as Green, Albanese, Cafri, and Aarons (2014), who studied the influence of leadership on service quality of working alliance described as the relationship and interactions between HC providers and clients. In this quantitative, cross-sectional, multilevel structural equation model (SEM), Green et al. (2014) argue that transformational leadership has a positive association with OC and found a significant relationship between leadership and climate ($\beta = .71$), but no correlation between leadership and working alliance. The relationship between leadership and working alliance was mediated by OC; thus, a positive OC supports HC providers in promoting positive working alliance.

Sutton, Family, Scott, Gage, and Taylor (2016) contend OC factors (role conflict and job satisfaction) influence HC workers' team cohesion while providing chronic care services in mental health. This qualitative, interpretative, phenomenological analysis suggests OC factors of role ambiguity, responsibilities, and lack of a common team goal may inhibit identification of clients' needs and care delivery. These OC factors were found to prevent the HC team from identifying patients' health care requirements and provision of care through team innovation and skill mix.

The literature supporting the influence of OC on HC workers' environment, employees' satisfaction and performance, and organizational commitment and performance is robust. Additionally, the influence of OC and how this relates to HC workers' mental health outcomes suggest that strong organizational leadership positively influences employees' perceptions of OC, which positively influences HC workers' mental health. Sutton et al. (2016) indicate that HC workers' perceive OC factors influence team cohesion, thus influence performance in provision of outpatient mental healthcare services. The context for much of this research is in the hospital setting where acute health care services are provided to patients. Therefore, the focus for this study is the influence of patients' perceptions of OC in the outpatient setting where ongoing management of chronic disease occurs.

Organizational Climate Influence on Managing Chronic Illness

Wolf, Dulmus, Maguin, and Cristalli's (2014) quantitative, comparative study argues that organizations with poor OC have higher rigidity, resistance, and stress with lower proficiency, engagement, and functionality. Research focused on the reengineering of patient primary care and chronic care models suggests that OC factors influence organizational capacity for change. Recent literature assessing the paradigmatic shifts in healthcare delivery support the influence of OC on change implementation. Kadu and Stolee's (2015) systematic review of implementing a formalized model of chronic care into primary care settings suggests OC factors as both facilitators and barriers to implementation. Factors of OC as facilitators include an organizational culture which promotes patient centered care, an implementation climate of commitment, and recognition and willingness to advance and manage change through incentivization and

leadership engagement. Factors of OC as implementation barriers include team inflexibility, poor organizational readiness characterized by lack of interest, decreased commitment and engagement from leadership, and reduced HC provider buy-in.

The chronic care model, a collection of evidence-based health care system changes to improve disease management activity (Wagner et al., 2001), has been widely adopted. Dickinson et al.'s (2015) quantitative, comparative, study examined primary care context factors of three chronic care model implementation approaches with secondary data analysis from a cluster randomized trial. The chronic care model was implemented to support patients with diabetes in primary care practices. Practice characteristics to assess change culture, work culture, and chaos where established from a Practice Culture Assessment survey at baseline. Patient-level diabetes outcomes measures of performance (blood levels, foot exams, blood pressure, and education) were assessed at baseline, 9 months, and 18 months. The findings suggest practice context plays a role in successful implementations of chronic care models (Dickinson et al., 2015). Both positive change and work cultures suggest inherent capacities needed for successful chronic care model implementation and overall practice context are factors (Dickinson et al., 2015).

Additionally, empirical studies support phenomena indicating that OC influences quality of care and patient outcomes for those with diabetes. Quality of care metrics and benchmarks, and diabetes outcomes measures are maintained in national and international databanks with established standards of medical care (ADA, 2018). The availability of robust data and standardized metrics and goals supports extensive opportunities for research.

Benzer et al.'s (2016) qualitative, hermeneutical study compared primary care clinics over 3 years to assess teamwork processes associated with high-quality diabetes care. Teamwork processes organize interdependent taskwork performed by HC workers in providing diabetes care. Teamwork processes are organized by transition processes (team mission analysis, goal specification, strategy plans), action processes (monitoring progress, system monitoring, team backup, coordination), and interpersonal processes (conflict management, motivation, affect management).

Semistructured staff interviews were coded as sensitizing concepts, and four psychological themes were developed (shared mental models, empowerment, psychological safety, workload). Clinic performance was categorized into four performance types (high, improving, worsening, low) from composite diabetes quality measures of 1,949 patients gathered from Healthcare Effectiveness Data and Information Set (HEDIS) over 3 years. Benzer et al. (2016) suggest a positive impact of the qualitatively identified psychological themes on teamwork processes. The clinics recognized as sustained high performers shared that work effort was not pressured, suggesting that staff are empowered to improve clinic processes and have autonomy. Sustained high performers also differed from the other three category performers in conflict and affect management processes, higher frequency of performance feedback, managing patient quality care reminders as a team, and staff (nurse) coordination. The psychological themes identified here are consistent with other studies of organizational culture and OC, and overall influence of patient outcomes and quality.

In researching the phenomenon of OC influence on patients with diabetes, Vargas Bustamante et al. (2017) suggest that primary care clinics with manageable clinic

workloads and high-quality of staff relationships influence experience and diabetes outcomes for patients of low socioeconomic status. This quantitative, associational, cross-sectional study compared measurements of 907 patients' blood levels and blood pressure across 14 community health centers in California. Multiple surveys supporting data collection included Patient Assessment of Chronic Illness Care (PACIC-11) on the patient experience; Agency for Healthcare Research and Quality (AHRQ) Medical Office Survey to assess manageable clinic workflows and quality of staff relationships; and Safety Culture and TransforMed clinician staff questionnaire.

Clinics were categorized by manageable clinic workload (low/high) and quality of staff relationships (low/high). Regression models of bivariate analyses of manageable workload, quality relationships, diabetes care processes, and outcome measures were conducted with errors adjusted to account for clinic clustering. Vargas Bustamante et al., (2017) found lower diabetes-related emotional distress was evident in clinics with high manageable workload and quality staff relationships (MCW low 0.53, high 0.57, p 0.03; QSR low 0.53, high 0.56, p 0.15). By contrast, clinics with a less manageable workload and lower quality staff relationships, patients' experiences of care were better (MCW low 0.50, high 0.46, p 0.05; QSR low 0.52, high 0.46, $p<0.01$). Vargas Bustamante et al. (2017) suggest the bivariate analyses statistically significant differences in patient characteristics could partially explain the contrasting findings. Diabetes care process measures were better in clinics with high manageable workload and quality relationships when compared to clinics with low manageable workload and quality relationships; however, no significant differences in diabetes care outcomes were evident between these practices.

Overall, Vargas Bustamante et al. (2017) findings support the body of research demonstrating an affirmative association between positive OC and better chronic disease processes and management. Manageable workloads and higher quality staff relationships in clinics influence maintaining quality of care guidelines for patients with diabetes and low socioeconomic status. Workload, personnel resources, and OC present in current research as factors impacting chronic care strategies suggest contemporary awareness of the complex relationships of HC workers, systems, and processes necessary to enhance optimal patient outcomes (Vargas Bustamante et al., 2017).

As healthcare continues to shift from the hospital to the physician's practice, the systems, processes, and HC workers must undergo change implementation to meet rising demand for access to care. These circumstances are challenging physician and staff workloads and influencing team cohesion and processes. Patients living with chronic illness experience individualized variations in self-care ability and symptom management over time adding care complexity (Paterson, 2001). The current literature (Kadu & Stolee, 2015; Dickinson et al., 2015) supports the phenomenon which suggests that OC acts as both facilitator and barrier to implementing systems and models that enhance chronic disease management. In addition, the research supports that the quality of staff relations influences both the patient experience and patient outcomes.

Organizational Climate Influence on Patient Perception and Outcomes

Braithwaite, Herkes, Ludlow, Testa, and Lamprell's (2016) systematic review examined the association between workplace culture and patient outcomes. OC was included in the larger construct of organizational culture. This review formulated the hypothesis to include organizational and workplace culture, with workplace capturing

subcultures of units, wards, departments, and employee groups of HC workers. The review included a wide range of healthcare settings in acute and primary care (inpatient and outpatient) at hospitals, practices, pharmacies, military settings, aged care facilities, and mental health facilities (Braithwaite et al., 2016). The synthesis captured 62 peer-reviewed, primary empirical studies garnered under PRISM and meta-analyses protocols searched in August 2016 from academic databases published since database beginnings. Of the 62 studies used, 58 were quantitative methods though none of randomized control trail design, four used mixed methods, and none used qualitative methodology alone. Study quality was assessed with 39 classifying as high, 21 medium, and two low (Braithwaite et al., 2016).

The findings suggest that in greater than 90% of the studies, organizational and workplace cultures correlate with patients' outcomes, with a majority (74.2%) determined as positive correlation and of those (48.4%) as exclusively positive. The other (25.8%) report a mixture of positive or no correlation, while no studies associated a negative correlation (Braithwaite et al., 2016). The 62 studies revealed significant diversity in measurement factors for both culture and patients' outcomes assessment; therefore, no meta-analysis was conducted.

Braithwaite et al.'s (2016) primary findings were broad hospital based including patients' outcomes of mortality rates, inability to prevent death after developing a complication, readmission rates, and adverse events/medication errors. Well-being outcomes included patients' satisfaction, quality of life, and mood. Clinically focused outcomes included pressure ulcers, falls, and hospital acquired infections among others. There were findings supporting organizational and workplace culture were positively

associated with patients' outcomes outside of hospital settings in aged care facilities and a community health center, though only reported in four studies.

Advancing the research of OC influence on patients' perceptions and outcomes, Perez (2007) utilized a secondary data set from the Minimizing Error, Maximizing Outcomes Study (MEMO) to examine practice chaos. A quantitative, associational, cross-sectional study of 119 national primary care practices assessed which characteristics define an unhealthy medical practice or workplace (Perez, 2017). Practice physicians and managers were surveyed on factors of time pressure, perceived work control, perceived focus on teamwork, professionalism, stress, and burnout. Patient medical records reviewed for medical errors and quality were compared to practices assessed as low (n=220) or high (n=193) chaos.

The results show an overall aggregate patient error score for low chaos practices (38.18, SD =2.43) and high chaos practices (43.14, SD 2.49) based on 0 = least, 100 = most errors. Further, the aggregate patient quality score showed low chaos practices (63.60, SD 4.62), and high chaos practices (59.07, SD 4.65) based on 0 = lowest, 100 = highest quality. Perez (2017) concludes that stressful practices are associated with adverse work conditions, dissatisfied physicians, and medical errors.

Lemaire et al. (2018) suggests that when patients perceive physicians to be busy or overworked, they may alter their behaviors during physician encounters to prevent overwhelming them. This exploratory, qualitative study conducted in physicians' office settings used semi-structured interviews and thematic analysis to explore patients' perspectives on physician wellness and how physician wellness links to patient care. Patients observe cues from the office pace and environment, like being rushed through

appointments by overwhelmed, busy, or overworked physicians. These cues influence patients' judgments about physician wellness, which may impact how patients' perceive their care (Lemaire et al., 2018).

Neumann et al. (2007) established a negative influence on physician empathy when cancer patients perceived a general busyness of hospital staff. Neumann et al.'s (2007) quantitative, associational, cross-sectional, retrospective study demonstrates the characteristic of patient-perceived busyness of hospital staff as the strongest influence on physician empathy accounting for 19% of the variance (β = -.44, p <.001). The determinant of patient-perceived general busyness of hospital staff had strong influence on physician empathy and had indirect influence on the patients' desire for more information about their own findings and treatment options (Neumann et al., 2007).

The phenomena of OC's influence on HC workers identifying patient care needs and care delivery is expressed in Nembhard, Yuan, Shabanova, and Cleary's (2015) study on patients' experiences of timely care in relation to voice climate at primary care clinics. Voice climate is defined as discretionary communication of ideas on work issues with intent to improve or enhance operational or organizational functioning (Morrison, Wheeler-Smith, & Kamdar, 2011). Measurement of perceived timely care included the ability to obtain appointments and see the physician as soon as needed, and timeliness of receiving test results.

The study analyzed 8,164 patients across 37 clinics. Patient perception data was pulled from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The CAHPS are nationally standardized patient experience assessments promulgated by CMS and required as a condition of participation for reimbursement by

Medicare and Medicaid (Guterman, Davis, Schoenbaum, & Shih, 2009). HC workers

(1,224) were assessed using the Leading a Culture of Quality survey to measure voice

climate, organizational focus, and alignment with leadership.

Nembhard et al. (2015) support a relationship of voice climate and professional

hierarchy for clinical and administrative HC workers and the patients' perception of

timeliness of care in primary care clinics. This quantitative study, a quasi-experimental

cross-sectional design, evaluated the link between staff's work environment and patients'

care experiences. Nembhard et al. (2015) proposed that differences in perceived safety of

voice climate within workgroups (leaders and staff) results in behaviors which create

process inefficiencies that adversely affect the patients' experiences of timeliness. The

results support that voice climate for individuals lower on the professional hierarchy

(staff) is more positively associated with patients' reports of timely care than the

perceived voice climate for leaders (Nembhard et al., 2015).

Nembhard et al. (2015) found that greater difference in climate scores between

the HC workers and physicians were associated with greater negative patient experience.

Nembhard et al. (2015) relates that this is an important focus for future research to assess

the behaviors thought to influence the relationship between the climate for staff and

patient care experiences to further understand these complex associations. A greater

understanding of the link between the staff and patient experience may help to inform

strategies that would support better patient care (Nembhard et al., 2015). This cross-

sectional study does not infer the causal relationship between staff perception of voice

climate and patient's reports of timely care.

Patient adherence, defined as the extent to which patients follow treatment or health behaviors recommended by their doctor, is an attribute of patient behavior (Dimatteo, Haskard-Zolnierek, & Martin, 2012). Horne, Weinman, Barber, Elliott, & Morgan (2005) concur patient nonadherence to appropriately prescribed medications is a global health problem. Additionally, nonadherence prevents patients from gaining access to the best types of treatment and this concern is particularly relevant for those with chronic illness. Horne et al. (2005) describe nonadherence as intentional and unintentional. Unintentional nonadherence occurs when the patient desires to adhere but due to lack of capacity or resources is unable to. Intentional nonadherence occurs when the patient decides not to follow recommendations. This intentional nonadherence is recognized in terms of perceptions, beliefs and preferences, that influence motivation to follow treatment (Horne et al., 2005).

A further consideration for adherence is the aspect of self-reporting (Horne et al., 2005). Patients share information about their health behaviors with physicians by self-reporting. Some patients may report higher adherence rates than what they achieve to present themselves positively (Horne et al., 2005). Patients' beliefs, biases, and cultural perceptions of a recommended treatment are found to consistently influence their personal need for such treatment resulting in varying adherence rates.

Saha et al., (2008) argue lower patient participation in the patient-provider relationship diminishes the strength of the relationship which may lead to less investment by both parties in following recommended care plans. Diminished investment, described as asking fewer questions of their provider who in turn provide less information, may influence the patient acceptance of and adherence to medical interventions.

Lazaras and Folkman (1984) defined stress as a relationship between the person and environment that is interpreted by the person as influencing their well-being. Additionally, coping is defined as shifting mental and behavioral methods to manage stimuli that are judged to challenge the person's resources. Personal health status is often determined by factors outside of one's control such as genetic makeup, or environmental exposure during development (Kelley, 2005). These influences are outside of patient's control. Patients are dependent on their caregivers and are often in a state of vulnerability (Kelley, 2005). Lazaras and Folkman (1984) suggest people who foresee outcomes based on luck or fate cope less favorably than those who believe outcomes result from their own behavior.

Empirical evidence demonstrates that an association of OC factors, including quality of staff relationships and workload manageability, influence better chronic disease processes and management (Benzer et al., 2016; Husdal et al., 2018; Vargas Bustamante et al., 2017). What is less understood is how patients' health behaviors and actions are influenced by their perceptions of the OC of staff stress in the office-based setting. Therefore, the research questions are, what are the patients' perceptions of physician office staff stress? How do the patients' perceptions of physician office staff stress influence patients' health seeking behaviors?

Chapter Summary

The present literature addressing OC demonstrates several aspects of influence on healthcare services at the physician, employee, and patient level. This review explored the context of OC in three primary themes of influence including the healthcare work

environment and employee stress, the implementation of systems and processes to effectively manage chronic illness, and patient's perceptions and outcomes.

Substantial findings across the primary themes suggest that OC significantly influences employee engagement and organizational commitment. Factors such as strong organizational leadership influence OC, which then influences HC workers' mental health, team cohesion, and the performance in providing healthcare services. Additionally, the research supports that the quality of staffs' relations influences both the patient experience and patient outcomes.

With the changing landscape in healthcare occurring to address the exorbitant cost of care, patients are receiving more services in the physicians' offices practice setting. This study will attempt to develop a theoretical understanding of how the environmental context, structures, systems, and players which are shared with and, more importantly, influence the patients' perspectives and their own health behaviors. The following research design methodology shall describe the study approach and processes, research context, data collection and analysis framework intended to answer the study questions.

Chapter 3: Research Design Methodology

Introduction

Chronic disease is the leading cause of mortality in the world (Stenberg & Furness, 2017) and the highest contributor to healthcare spending (Department of Health & Human Services, 2014). To help reduce costs, ACA policies designed to transition patients managing chronic disease from hospitals to physicians' offices have been implemented. Additionally, policy makers are redefining the role of patients from consumers to co-producers of their care (Coulter & Ellins, 2009). This study addressed the topic of how organization climate influences the patients' perspectives in the physicians' office setting.

Patients' perceptions and judgments of physician wellness (demeanor, physical appearance, general impression) may influence their feelings of trust and comfort, as well as their health behaviors (Lemaire, Ewashina, Polacheck, Dixit, & Yiu, 2018). The physician-patient relationship or working alliance has been shown to be closely associated with patients' adherence to treatment (Fuertes, 2007). Additional research supports an association that aspects of OC influence better chronic disease processes and patient management in the physician office practice (Benzer et al., 2016; Husdal et al., 2018; Vargas Bustamante et al., 2017).

The study design employed qualitative, specifically grounded theory methodology (GTM). GTM has broad qualitative applicability to inquire into subjective meaning or social production of issues, events, or practices (Flick, 2014). For example, Stenberg and

Furness (2017) constructed GTM conceptual model stating that living well with a chronic disease encompasses the role of patient self-care. The study adopted a GTM approach to assess the influence of health trainers (HT) or lay person health workers on outcomes of health behaviors from the patient perspective. The GTM approach similarly has applicability to assess the patients' perceptions of OC of physician office staff.

This researcher's study used GTM with a constructivist approach. Constructivists study how and sometimes why participants construct meanings and actions in specific situations (Charmaz, 2014). The constructivist approach treats research as a construction which occurs under specific conditions.

This study was in the situational conditions of research. Charmaz (2014) asserts that the constructivist approach aims at gaining a broader recognition and understanding that the phenomenon is part of larger and possibly hidden structures, networks, situations, and relationships. This means that the researcher must be alert to conditions where differences and distinctions surface. Researchers and research participants interpret meanings and actions. Constructivism fosters researchers' reflexivity about their own interpretations and their implications as well as those of the research participants (Charmaz, 2014). Utilization of reflexive memos were a key component to allow for the self-exploration of study meanings and actions throughout the process.

Research Questions

The intent of this research is to gain a deeper understanding of the perceptions of physician office staff stress by patients living with chronic illness. The study was designed to construct a theory of how patients' perceptions of physician office staff stress

influence the patients' health seeking behaviors. The following research questions therefore were presented to further explore this phenomenon:

R1. What are the patients' perceptions of physician office staff stress?

R2. How do the patients' perceptions of physician office staff stress influence patients' health seeking behaviors?

Research Context

The location was the central New York county of Onondaga with a population of approximately 465,000 ("United States Census," 2017), an area of mid-sized urban geography. The study was situated within physician office practice settings. Situational demographics include the physician practice type; for this study, the principal focus was primary care practices. HC workers in primary care practices interact daily with patients who are dealing with chronic illness. Primary care practices were predominant in the literature review and provide an opportunity to conceptualize a theoretical framework of patients' perceptions of physician office staff.

Patients managing chronic illness are frequently referred to physician specialists (urologists, oncologists, neurologists) who provide consultation as requested by the patients' primary care physician. Because these patients interact with a wide range of practitioners including their primary care and physician specialists, their perceptions of staff in multiple settings were shared as these experiences globally inform their lived experience. Gaining a better understanding about the various physician practice contextual factors provided clarity and further insight about patients' perspectives which otherwise may have been left explicitly unstated.

Research Participants

Charmaz (2014) supports the theoretical sampling methodology which can be designed and scalable to fit the project size and scope. Charmaz (2014) describes an approach to theoretical sampling in which the researcher first enters the field and conducts extensive ethnographic observations of numerous phenomena and subsequent informal conversations with participants to begin data gathering. Additionally, document review provides a significant type of data collection and enters the research as either primary or supplementary sources of data (Charmaz, 2014). The researcher then conducts intensive interviews wherein the participant does most of the talking to explore their substantial experience with the research topic. At this point, theoretical sampling is employed to shape and fill out emerging categories (Charmaz, 2014).

Given the sensitivity of the field setting and patients as research participants, this study waived ethnographic observations and extensive document review. The research participants were adult patients with chronic disease who receive care in primary care physicians' office practices. GTM research supports a smaller sample size; however, this is influenced by the nature of the topic and strength of the research questions (Charmaz, 2014). Initial purposive one-to-one intensive interviews were conducted with the goal of obtaining 10-12 total participants. Guest, Bunce, and Johnson (2006) contend that heterogeneous samples, poor quality data, and vague inquiry may increase the number of interviews; however, they conclude that 12 will suffice for most research on common themes and experiences. Therefore, a sample size goal of 10-12 interviews was planned.

Two primary care physicians agreed to sponsor this research and referred patients identified with chronic disease who appeared agreeable to participate in one-to-one

intensive interviews. One study participant requested a second intensive interview which

presented an opportunity for a deeper theoretical probing (Charmaz, 2014).

Instruments Used in Data Collection

Intensive interviews are typically used by grounded theorists and create a space

for interaction where the participant can comfortably share their experience (Charmaz,

2014). During the interview, the interviewer encourages, listens, and learns while the

research participant shares extensive phenomena experience. The participant does the

majority of the talking with prompting by open-ended questioning.

Data collection from intensive interviews was obtained from a series of open-

ended questions designed to encourage study participants to describe their care

experiences, perceptions of staff behaviors, and interactions as well as to relate their

personal reactions to these perceptions. The researcher led interviews began with open-

ended questions; this allowed each participant to explore and share their experiences and

observations, while keeping the researcher in the background (Charmaz, 2014). The

refinement of open-ended questions by the researcher occurred over the data collection

period as acquired data and data coding influenced the thematic perspectives of inquiry.

This process helped to assess the theoretical adequacy of categories.

An interview guide (see Appendix A) was proposed to frame nonjudgmental

interview questions, aid a smooth encounter, focus the research interest, and guide the

interview process (Charmaz, 2014).

Procedures for Data Collection and Analysis

Coding and memoing was imbedded throughout the process of analyzing data in

GTM (Flick, 2014). Interview transcripts were assessed through a process of data coding

which allowed for the development of data categories, properties, and relationships between them. There are variations of this process proposed and debated by GTM scholars Glaser, Strauss, Corbin, and Charmaz; however, researchers can utilize a specified scholarly model or combine aspects of more than one depending on which meets the needs of the research (Flick, 2014).

Coding was conducted in three steps and started with open coding, designed to express data into categories and concepts (Flick, 2014). The next step was axial coding, which identified and classified links between the central categories and concepts. This process served to discover and develop relationships between the categories and concepts. The third stage was selective coding, which further developed and integrated categories and concepts on core variables and on the central phenomenon of the study. The constant comparative method is an inductive process of comparing data with data (Bryant et al., 2011).   Constant comparison generates theoretical properties of the category by relating back and forth between the data for comparison; it was conducted at each level of data analysis (Charmaz, 2014). Constant comparison is systematic and circular, as codes and classifications are continually integrated into the further process of comparison (Flick, 2014).

Memoing was performed throughout the coding process as a mechanism to enhance theory development, shape and analyze data, and support conceptual theorizing (Flick, 2014). Memoing helped the researcher avoid placing past experiences and personal assumptions into the data. Additionally, the practice of methodological journaling allowed the researcher to step back and take a fresh look at these phenomena (Charmaz, 2014).

The primary approaches utilized in GTM data analysis are induction, deduction, and abduction (Bryant et al., 2011). Induction is a process of studying a range of individual cases and extrapolating patterns to form a conceptual category. Deduction is described as reasoning that starts with the general or abstract concept and reasons for specific instances. Abduction is described as reasoning that begins through data assessment to search for explanations toward hypotheses (Bryant et al., 2011). Each defined data analysis approach was utilized with emphasis on induction and deduction approaches.

The primary goal of utilizing a GTM was to arrive at a theoretical framework or model. The model extends an anchor for the reader and provides a visual demonstration of the theory (Charmaz, 2014). The developed conceptual model attempted to fit the intended audience of healthcare leaders and practitioners and explain some significance of how organizational climate influenced patients' perceptions of staff stress and patients' health behaviors.

Summary

This study proposed a GTM to better understand how physician office OC influenced the patients' perspectives on their health behaviors. A constructivist approach was practiced. The intent was to construct conceptual categories to shape a thematic model of the phenomenon.

All research study processes occurred in strict compliance with committee, St. John Fisher College, and IRB requirements. Additionally, this research was conducted with integrity, collegiality, and professionalism.

Chapter 4: Results

Introduction

To gain a better understanding of patients' perceptions of OC among physician office staff, this study examined patients living with chronic illness and their perceptions of the staff in the physician office-based setting. The study results were achieved by conducting intensive interviews with patients living with chronic illness. These patients were referred by two primary care physicians who agreed to support this research project.

Study participant interviews resulted in more than 165 pages of transcribed data of responses to the interview questions. The interviews offered extensive reflections on personal perceptions of physician office staff interactions and communications. Every participant agreed to review their finished interview transcripts which were provided to each individual. No additional participant exceptions or corrections to the transcripts were provided to the researcher.

Data analysis and findings shaped four primary thematic categories: seeking connection, valuing human touch, perceiving busyness, and developing relationships. These categories support and inform an emerging conceptual framework of patients' perceptions of their relationships with physician office staff. This chapter provides an in-depth assessment of the research findings with a focus on the four primary thematic categories and a conceptual assessment of the interpreted perspectives.

Answering the Research Questions

To warrant referral to this study, the participants were identified as patients with chronic disease by their respective primary care physicians. The decision of whether to contact the researcher for an interview was the sole discretion of the participant. Meetings were scheduled at the participants' preferred location and included a hospital, public locations at a coffee shop and restaurant, the participants' workplace, and their homes.

A series of interview questions (see Appendix A) was designed to encourage participants to share their perspectives on several aspects of interactions with their primary care physicians' offices. The interview questions were broadly grouped by theme: health status, health partnership, and health management. One-to-one intensive interviews with 11 patients were conducted; one patient was interviewed twice at his request for a follow up. Of the 12 interviews, 10 were self-transcribed by the researcher, with the final two submitted to *scribie.com* for facilitation. The transcripts were open coded to express data into categories and concepts. The codes were further compared by constant comparative method generating theoretical properties of categories (Charmaz, 2014). The participant responses were then organized by primary focus area based on the participants' feedback.

The findings revealed rich, detailed patient perspectives about their experiences and interactions with multiple actors both within and peripheral to the physicians' offices. Participant interview excerpts are referenced throughout as (x, y). The (x) is an anonymous participant number and the (y) is the interview transcript page number.

Primary focus codes and concepts were extrapolated from these data and coalesced into major thematic categories of seeking connection, valuing human touch, perceiving busyness, and developing relationships. From these four categories, the overarching core theme of patients' perceptions of staff relationships evolved. The following presents each thematic category contextualized in depth.

Data Analysis and Findings

The study participants included six males and five females. One male was interviewed twice at his request. Most of the participants (n = 10) stated they had been patients of their primary care physician for more than 20 years. All but one described having one or more chronic illnesses included diabetes, heart and blood disorders, lung and breathing conditions, cancer, behavioral health disorders, neurological disorders, and chronic pain.

Health Status

In response to the interview questions (see Appendix A) thematically grouped as health status, the participants were asked to describe their overall health status and to elaborate upon how this is going for them. Some participants suggested luck or being fortunate when describing aspects of their health status: "I've been lucky" (3.0, p. 3) and another: "I'm very lucky ... I've got good doctors." (11.0, p. 10). A third participant describes luck in the future sense of illness: "Cross my fingers it doesn't turn into leukemia." (7.0, p. 4). While another reflecting on her recovery: " ... knock on wood, I'm 99% better than I was in the last year." (8.0, p. 1). Patients must cope with their chronic illness, and their ability to do so is contingent on multiple factors. Perceptions of luck suggest health status factors outside of their control (Kelley, 2005; Lazaras & Folkman,

1984). Patients' vulnerability may be heightened with illness, the need for a trusting relationship with their physician is vital.

Participant responses that described their overall health status covered a spectrum from "very healthy" to "not great" provided a likely reference to their current psychological state of having wellness or illness in their mental foreground (Paterson, 2001). The health status concept emerged as a foundational aspect of the conceptual framework which informs the overarching core theme of patients' perceptions of staff relationships. Examples of self-described health status are noted in these participant interview excerpts:

> I feel great, I just do. I'm being treated for several different things but an aneurysm to A-fib, prostate cancer and something else a neurologic problem that effects my balance and my legs. But other than that, I'm still walking, talking, breathing so I'm happy. But other than that, I'm good. (4.0, p. 1)

This participant, a gentleman over the age of 80, described that getting old is no problem; rather it is the health issues that come with age that challenge him. His description of his current health status indicated one of wellness in the foreground, as he stated, "I'm happy ... I'm good." On the participant self-description continuum of overall health status, this next description is shared by a woman of 80 who experienced the loss of her spouse in the past year:

> Well, it's sorta mediocre I guess, I have diabetes for many years. I've been a little unsteady on my feet. Overall, I'm not sickly although I just went through a bout of pneumonia that lasted for about a month. But basically, I'm fairly healthy. (9.0, p. 1)

Her self-descriptors of "sorta mediocre, fairly healthy" suggested she is somewhere in between well and illness on her psychological foreground. The next example of describing overall health status is a gentleman who still works full time. His perspective inferred the phenomenon of having illness in his psychological foreground:

> Um, not great ... Couple years ago I was told by my primary care physician I was prediabetic. And so, got a little nervous about that, did not make any drastic changes over the last couple of years. Still ate poorly and actually my most recent visit which was about a month ago I go put on insulin. I also got diagnosed with blood cancer about 3 years ago. ... my understanding is I will die with it but likely not because of it. (7.0, p. 1)

Lastly, another participant described her relationship with her primary care physician as "he always keeps a short leash with me" (8.0, p. 1). While she considered herself as historically stable health-wise and noted she is relatively stable now, she more recently suffered a series of serious health conditions and, because of this, is followed closely by her physician. This suggested the experience of having illness on her psychological foreground both recently and episodically. These sample quotes highlight the spectrum of responses from "very good" to "not great" about self-assessed health status reflecting a snapshot of participants' mental frame of chronic illness (Paterson, 2001).

Applying Paterson's (2001) concept of illness or wellness on the psychological foreground, a comparison of these four participants' (4.0, 9.0, 7.0, 8.0) perspectives is demonstrated along with quotes used to describe physicians' office staff. A listing of the four participants' self-assessed health status response in order from "very good" to "not

great" presented with the descriptive language quotes each stated when referencing staff

is depicted in Table 4.1

Table 4.1

Self-Assessed Health Status and Descriptors of Staff

Participant	Participants Describing Staff			
"Feel great, I'm good" 4.0	"staff have been great"	"a screw-up on the part of the staff, that happens"	"They do a nice job there"	
"Sorta mediocre, fairly healthy" 9.0	"very helpful"	"I ask for S. she is more accommodating"	"A lot of confidence in S. she knows me well"	
"Not great" 7.0	"getting more of a personal long-term connection"	"I recognize a couple of them"		
"Always keeps a short leash with me" 8.0	"is horrible"	"leaves something to be desired"	"can't get past them"	"the staff is huge"

This brief comparison suggests an influence of the participants' health status state of mind on their characterizations of the physicians' office staff. Patients recognize interdependence between themselves, the physician, and the office staff. When the patients' health status is illness on the psychological foreground, their expectations of the office staff may be heightened. This heightened expectation potentially sets the staff up for lower chances of meeting the patients' expectations, thus creating tension.

44

When the patient's health status is one of wellness on the psychological foreground, their expectations of staff may not be heightened; thus, an opportunity for tension created between patients and staff is less likely. The current state of the patient's psychological foreground may also influence their perceptions of physician office staff stress.

Perceptions of Staff Relationships

The corresponding second and third thematic groups (health partnership, health management) of interview questions (see Appendix A) encouraged participants to describe several aspects of how and when they interact with the office staff, as well as, how they have learned and who has helped them learn to stay healthy. Further, participants were asked to describe who do they engage with when they have questions about healthcare instructions, in addition to elaborating on anything the staff could do to help them feel more able to stay healthy. The interview data analysis informed the thematic concepts and categories resultant in the core category of patients' perceptions of staff relationships.

The following analysis delivers the study theme, categories, concepts, and dimensions listed on Table 4.2. Each category elaborates on participants' perceptions and is further analyzed as part of a broader construct. Patients with chronic illness are usually in life-long campaigns for living well with their ailments. The key to enhancing their success is defined by the working alliance of the physician-patient relationship (Fuertes, 2007). Study participants described their relationships with staff as a comparably significant phenomenon to the physician-patient relationship. Additionally,

trust, compassion, and empathy were repeatedly described as primary attributes sought

from staff-patient relationships.

Table 4.2

Perceptions of Staff Relationships

Categories	Concepts	Dimensions & Properties
Seeking connection	Staff as proxy to physician	Trust Empathy Compassion
Valuing human touch	Navigating systems	"Okay, next" Environmental complexity
Perceiving busyness	*"See 100 of these a day"*	Stressed systems Frustrating processes Automation / Factory
	Needing access	Assigning physician quality Waiting times Visiting the NP / PA
	Recognizing staffing (resources)	Becoming stressed Cramped spaces Short staffed Staff turnover
Developing relationships	Communicating with Staff	Bothering staff Wanting follow through Changing technology

Seeking connection. The first thematic category of seeking connection arose

from participants' described aspects and context about their perceptions of connecting

with staff as proxy to the physician or staff empowered to act on behalf of the physician.

Patient and office staff interactions and exchanges occurred within the systems and

processes of health care in which all actors are required to interface. Observations,

interactions, and assumptions were described from experiences with staff of both primary care physicians' offices and specialists' offices. Additionally, interactions with advanced practice providers (APPs: physician assistants, nurse practitioners, certified diabetes educators) in both office settings were recounted.

Patients seeking connection with staff is perceived as essential to easing the process of navigating the inherent complexities associated with managing chronic illness. Patients must feel welcomed and comfortable in the office environment to connect with staff. One participant described his partnership with the staff as "very strong, I don't feel isolated from the doctor." (1.0, p. 4) Another patient shared this observation with reference to her staff connections, "I don't feel like I've ever been neglected up there." (9.0, p. 5) These descriptions emphasize the concept of patients connecting with staff as proxy to the physician and the perceived significance of establishing and maintaining positive staff relationships as a vehicle for connectedness to the physician. Seeking connection with staff proxy to the physician in the broader context of the necessity to follow the required processes and systems while managing one's healthcare was expressed in terms of establishing trust and experiencing empathy and compassion.

The participants described an array of experiences and perceptions of office staff resulting from multiple encounters. Many noted personal relationships have developed over time, and the staff are viewed as trusted allies. The participants described the staff with admiration, trust, and as respected partners in their journey of managing chronic illness:

> He had me go speak to his female nursing practitioner, who was right down the
> hall. And the support, the compassion, the love that they showed me, she showed

me also, I'm also mentioning Dr. Y, but she showed me was like a mother compassion you know what I mean and I got through my situation and you know I just love them for that. I love all of them for that. (6.0, p. 6)

Another participant described her affection for a certain staff member she interacts with stating, "Oh, god, I love her. I love her." (11.0, p. 7) Still a third participant recounted positive interactions with office staff:

Every person that I deal with in that office is easy to speak with. Very cordial, very nice, again no attitudes. No, I never feel as though I don't want to go there. It's great, I've never had a bad experience there. (1.0, p. 3)

There were other participants who described a sense of feeling distanced from the physician. This experience increased the participants' perception of remaining on guard or heightened awareness and vigilance of their health oversight: " ... you do kind of like you know how you want to be treated. And sometimes you know how things can fall through the cracks so I kind of watch for those things that they aren't happening to me." (3.0, p. 3)

Patients seeking connection with the staff proxy to the physician requires that their expectations of care and follow up occur as needed. This expectation was referenced for both the primary care physician and the referred physician specialist. As each patient has his or her own expectations of what should occur and when, a tension is created between the office staff and the patient when expectations are not met. Patients managing chronic illness are vulnerable because their care is dependent on both the physician-patient and staff-patient relationship that can become challenged when staff do not meet patients' expectations:

Now Dr. A. referred me to this guy, and I know that he's good, but I would call

and get into their voice mail to leave a message you would never get a real

person. And then they would never call you back. So, you'd be following up and

following up. I was having these problems last year I ended up at hospital in

Rochester and so when they were working with me and they were like we can

follow up with you in 6 months or whatever or you can go back to your

neurologist here in Syracuse because they were like you've got a really good one.

So that's really good to hear. So, I know that the neurologists are good, it's just

that the office staff like leaves something to be desired. (8.0, p. 3)

This participant's shared experience explores complex relationship dynamics between the

patient, the physician, and the office staff. While she reaffirmed twice that the

neurologist is good, once because her primary care physician referred her and again

because other neurologists in Rochester confirmed this, she remains unsatisfied with the

staff. This participant's experience influenced her trust and confidence in the staff's

performance and ability to act competently as proxy to the physician.

A second participant offered a global perception resulting from the absence of

connecting with staff proxy to the physician as referenced from her office visits. Her

long-standing relationships with physicians were enough to keep her loyal to their

practice, however, her experiences are compromised:

There are doctors that I go to only because I've been going to them for years and

at this point, why change? But I don't enjoy it and you know, a lot of it does

have to do sometimes with not just the doctor but the staff. If you know, if you

don't feel comfortable asking the question, or you feel first of all like you waited

for an hour and a half for your appointment and ... you're in and out in two

minutes and pay your bill. You know that kind of thing ... just want to throw

your hands up and say I don't want to come back here. (5.0, p. 3)

The shared construct of these examples is the influence of the relationships with

staff proxy to the physician and the relevance of establishing trust with staff. The

participants described that positive patient-staff relationships influence a culture of trust

and competency with the physician and with the practice as an entity.

In addition to the importance of experiencing trust and compassion with the staff

proxy to the physician, two participants described the need to feel empathy from staff and

a third shared that teaching empathy to medical personnel early in their careers should be

a priority:

Do they have classes here that teach them how ... or is it like ok here's a 4-hour

study block and we probably should be? ... More training on how to engage

patients in a positive way to get better outcomes. ... You get continuing education

credits, every 3 months you have to go be nice to your patients' class, you know?

How do you change their behavior? (7.0, p. 12)

This participant related this next experience as needing empathy because of the staff

focusing on process during a clinical exam:

Then this guy who did an EMG ... and he was like totally mechanical almost

about it right? ... but he was very much like there wasn't a whole lot of empathy,

he's like it (the symptoms) could be from diabetes and this, that and the other

thing and I'm like wait it minute it is just like all mechanical. (8.0, p. 8)

Lastly, this description of needing empathy centered on connecting with staff proxy to the physician and wanting to be heard, not patronized:

> The thing you want to feel is you're being heard; you're not being rushed. You're not being pat on the head and saying oh well you know, [sarcasm] I mean everybody feels that way or everybody gets that, or this is nothing or because it might be big to you ... I think we've probably all been treated like that at some point ... it's the listening whether it's the doctor or the nurse or the person on the phone I think it's the listening or feeling like they are listening. (5.0, p. 3)

She continued with her perspective about when her experiences have gone as expected, with empathy threaded through this explanation:

> The good moments, the people that are warm and friendly with you and want to make sure that they help you whether or not it's to get the message to the doctor and ... see that he calls you back and that kind of thing. They understand if you're kind of panicky about something, those are the good things. (5.0, p. 3)

This excerpt illustrated the significance of her connection with staff proxy to the physician. Patients interpret this as the link which protects them from feeling isolated from their physician. Her description of being panicky highlights the vulnerability experienced by patients, particularly those who live with and manage chronic illness.

Valuing human touch. The second thematic category valuing human touch was recognized by three participants' perceptions interpreted by the noticeable shift in healthcare. The shift in emphasis to one about business and less about the human experience was noted by this perspective of: " ... I don't know, medicine has become such big business." (9.0, p. 5) These perceptions provided further context to recognizing

the business of healthcare as interpreted from the personal interactions with healthcare

systems. Process automation was referenced in relation to medication renewals through

the pharmacy and electronically linked from the physician's office. This participant

described the systems connectedness:

> One thing I've noticed with this new computerized system, if there's something
>
> going on at Dr. Y's office, Dr. W knows about it 'cause he can see it on the
>
> screen. And I think that's a good thing, so everybody knows what everybody else
>
> knows. Or if you get blood results, they go to everybody, I think, because they all
>
> seem to know what they are. It's like a factory. (12.0, p. 22)

The automation and factory perceptions continue with this same participant:

> Well, I mean it's okay. It's not bad. He spends enough time with me. But you can
>
> tell, just by the way that the system works. It's like automated. You're next. He
>
> comes in. He does the reading. Any questions? This is this and this is that. And I
>
> ask him questions and he's good. He'll sit down and talk and then that's it. Okay,
>
> next. (12.0, p. 18)

The perception of a factory and processes related to moving through the components of a

patient office visit provide additional background to the category of valuing human

touch. This participant shared a particularly astute observation which associated the

business aspect with the environmental complexity necessitating expertise:

> But I've noticed that over the years that there's more people in the office and
>
> learning more different things ... And it's very complicated now with all the codes,
>
> the medical codes and so you sort of have to be a specialist in that kind of thing,
>
> before you can work in that kind of an environment ... and there's 10,000 different

insurance plans and it's just a mess. And I don't know how much, I'm not into the numbers but you hire two more people, my goodness they cost money. And if they're getting reimbursed less then I don't know if it's. ... It must be the business that gets reimbursed less. (12.0, p. 18)

This observation indicated a more in-depth level of understanding about the business complexities of healthcare delivery in a physician's office. While other participants described singular aspects of their perceptions of office automation, this excerpt encapsulates many of the pressure points of the physician office environment resulting from factors exacerbating the complexity of the business of healthcare. The systemized aspects of healthcare service provision have detracted from the human touch experience patients seek.

Amid the swirl of the business of healthcare and the inherent complexities of navigating systems, the routinizing of care was perceived by this participant who emphasized the need to experience a more empathetic approach:

I'm sure it can get routine right? But still putting yourself (staff) in their (patients) shoes especially if it's a serious illness that you don't know anything about and you don't have answers for ... the tests are routine to them, but for someone who is going through that and not knowing what they've got ... that's a lot to go through. (8.0, p. 8)

Managing chronic illness requires frequent interactions with complex healthcare systems. Healthcare has experienced an accelerated rate of change, and this is influencing the patient care experience. Five of the participants stated their age of 70 years or older. As age advances, occurrence of chronic disease often increases, requiring older patients to

seek more healthcare services at a time of unprecedented change. The continuity of patients' relationships with staff and the physician hinges on trust, compassion, and empathy.

Perceiving busyness. The third thematic category of perceiving busyness was referenced by six of the 11 participants who shared perspectives about the state of activity observed at the physicians' offices. The construct of perceiving busyness was expressed as resulting from multiple phenomenon which patients encountered over the continuum of managing their chronic illness. Those patients who manage chronic illness need to frequently interact in partnership with the physician office to address health management issues. Several concepts which inform the construct of perceiving busyness were described from these interactions.

Patients' perceptions of office busyness were expressed in three distinct concepts. The first provided context to office busyness in general from observations of the volumes of patients being seen or cared for by the practice. The second concept described the overall office busyness as interpreted from the patients' perceptions of needing access to the physician both prior to the first appointment and while waiting in the office. The third concept is suggested that the patient becomes a contributing factor of staff busyness by bothering the staff when contacting them. Patients experienced and identified with the busyness which occurs at their physicians' office; however, their interpretations of that perceived phenomena are disparate.

This participant provided a perspective on volumes of patients and how this influenced her care experience:

I get that they probably see 100 of these a day or in a year whatever it is ... but my

situation is unique and so is everybody's and I get people are coming in for a cold

or their routine stuff, like that's the norm. (8.0, p. 8)

This observation highlighted her interpretation of the individualistic nature of every

patient's needs as well as the associated challenges met by office staff in working to meet

these needs. This participant recognized the volume of patients who are seeking care and

that everyone's situation is unique. The expectation that staff should individualize each

patient encounter is expressed.

Another participant's perceptions of busyness and volumes of patients clearly

suggest a relationship between office activity and organizational climate:

They got me in, but he couldn't see me. He was terribly busy. (I saw another

doctor) He was a pulmonologist. ... Anyways, I saw him. He was very good, but I

just asked him about Dr. Y. "Oh, he's terribly busy now. He's scrambling," or

something like that. This was back then. Now, it's much different. Now, he seems

to be very relaxed. I don't know if it's because he's got fewer patients or he's

taking fewer patients or he might not be taking new patients. (12.0, p. 20)

His description of the practice now being different, and the physician is more relaxed is

attributed to the apparent reduction in volume of patients seen in the practice. This state

is a change from an experience when he had to see a different doctor for a visit because

his doctor was so busy, described as "scrambling". Therefore, his described experience

infers that the busy practice is stressed, and that the less busy state is a more relaxed

environment.

A second concept of the thematic category perceiving busyness is the patients' experience and interpretation of needing access to the physician. Needing access is described first by one participant in relation to the phenomenon of waiting for care:

> I'm going to see a new guy, Dr. J, I haven't seen him yet. He's a plastic surgeon. ... But it takes 3 months to see him. I was hoping I could get in sooner, but I can't. It's toward the end of July, and then my appointment was made early in May. I'm on the waiting list, but ... There just aren't any openings. So anyways, but he's supposed to be very good, and I guess that's why he's busy. (12.0, p. 6,7)

This perception suggested that the limited access and extended wait time to see the physician is an interpretation that the physician is high-quality. Still another participant described her perceptions of busyness from the experience of needing access to her physician when she had symptoms:

> I called and said I feel terrible I've got a fever, I need to get in to see somebody, so, Dr. A is I think the busiest doctor up there, he really is. But I saw one of the other doctors but I'm just more comfortable with him. No, I think it's hard, when I call, I want to see Dr. A can't always do that. (9.0, p. 5-7)

A further dimension of perceived busyness and the concept of needing access is the shared experiences of waiting at the physician office. Patient waiting is an occurrence and even an expectation as part of the physician office patient appointment process. One participant described her realistic expectations of waiting:

> Sometimes I wait yes. I go to a doctor expecting to wait though you know. I expect an hour minimum. You know if I get in before that I pretty, I take a book

it's my relax time. It's like yea, I'll just hang out here and read and when I go in,

I go in. (3.0, p. 4)

The perception of waiting is individualistic, as a half hour wait can be interpreted either

as too long or not that long:

She said you have to wait a really, really long time to get in. I said well I'm used

to that it's not anything very seldom when you see a doctor when you're supposed

to. But you know, half an hour max both times. He was really very good. (4.0, p.

5)

However, this same participant's experience described one encounter which did not meet

his expectations for waiting:

Had an appointment last fall ... and they do a sonogram first and I had to sit and

wait an hour and a half. And that was unusual. When I finally went in to see the

doctor, she said how are you and really not well, I had to sit out there for an hour

and a half. It was a screw up on the part of the staff and that happens. (4.0, p. 4)

This description of an extended wait time resulting from a perceived staff mistake may

reflect the state of office busyness or a harried or inexperienced staff member. Perceived

office busyness was described in the concept of needing access interpreted through the

experience of extended waiting. The patients' interpretations of waiting have multiple

meanings which include limited access to see their physician, limited access equates to

high physician quality, and extended wait times to see the physician at the time of the

patient appointment.

Visiting the nurse practitioner or physician assistant added dimension to the

concept of needing access as recognized by these observations:

In the past, he seemed to always have a lot going on. Maybe in the midpoint of his

career, he was busy, had a lot of patients, and if you went to see him, you're lucky

to see him, you'd normally see the physician assistant. (12.0, p. 3)

Another participant elaborated on a visit with a nurse practitioner:

And I don't know who I'm seeing, or maybe I do. I went in for a tick bite a couple

of years ago and I saw NP. She was very good. But when I went in there, I

thought I was gonna see Dr. Y. but he wasn't available for some reason, so she

took over. (12.0, p. 8)

A third participant described willingness to see the physician assistant when the reason is

for something which is believed to be straightforward: "I know the primary care I go to

sometimes used to be busy and I'd have something that I would consider relatively

simple and they would say would you like to the physician's assistant? I'd say sure."

(4.0, p. 6)

Patients managing chronic illness recognize the value of the health care team of

professionals and expect that other clinical practitioners will often substitute for the

physician. When seeking care and the option to see a nurse practitioner or physician

assistant is the difference of having access or not, most often patients will choose to see

the practitioner that is offered.

The third and final concept of the thematic category perceiving office staff

busyness is the patients' perceptions of recognizing staffing or resources. Recognizing

staffing and related stressors is described conceptually from patients' interpretations of

staff interactions by phone and in person. Three participants described the perceived

environmental factors contributing to office staff stress. The shared descriptions of a lack

of staff to adequately support all the patients' needs evoked the concept of staff turnover resulting from stress and burnout on the job.

Interpretation of environmental factors having an influence on office staff stress was shared by this participant's perceptions. His experience while waiting in the office for an appointment allowed him time to observe the staff:

What I've noticed each time that I have been there, is they are kinda sitting down, maybe three or four people, and I don't know what they are talking about, but I can only imagine that being in a confined area for eight hours to whatever hours of the day that they do, I can imagine how stressful that can be ... it's just kinda like when you have just women working together. For some reason, women, and no disrespect but, you know they just cat, cat, cat, they can be, it can be that and I don't think to a degree, men don't really do that. (6.0, p. 5)

This participant observed staff interactions among themselves as a group. This perception focused on aspects of environmental undercurrents which should otherwise be transparent to patients. The description of extended periods of space confinement and the reference to interpersonal relationship issues are interpreted as contributors to office staff stress. This observation coincides with Perez (2017), suggesting stressful practices are associated with adverse work conditions, dissatisfied physicians, and medical errors.

This second participant elaborated on recognizing staffing when asked if she could think of anything that the staff could do differently that would help her more or in a better way:

Probably not because I think you have to have a lot of extra help; I think to do things like that. It's just like it, well, what I started to say is they don't have

enough help. When you look at all those envelope things (medical records) they have there I think oh my God, there is so many patients and there are five doctors in there now. (9.0, p. 5)

The perceived lack of help provided context to her perceptions of recognizing staffing. She related that the volume of patients and practice busyness required ample staff resources to help her and all the patients. Her interpretation is that there not enough staff to support her more or in a better way. She did not identify what specifically the staff could do to help her more, just that she does not feel there is enough staff to help her.

This next exchange provided a third participant's perceptions of recognizing office staffing and his interpretation of staff turnover described from his phone call interactions with staff:

Anytime I've ever had to call back in years and years and years I've never had a problem. And also, in his office ... I don't recall them being there years and years and years. At some places you'll have the same people there for years, but there seems to be a bit of turnover there ... I worked at a place before where they worked people hard for 3 years and then they burnout and leave cause they'll bring in more people. They'll burn them out because when we get more people then they're cheaper again. I like to think they don't do that there, but? ... Do they not treat their (pause)? I have no idea to know why looking at, sitting right here, right know, why it seems like perhaps there's more turnover than maybe there should be. (7.0, p. 9,11)

This description characterized his perceptions of the challenging work aspects and dynamics of office staff. His use of the term "burnout" suggested the stress experienced

among physician office staff was serious enough that staff choose to leave their positions. These excerpts reveal that patients' perceive the office activities and staff were frequently busy and that the office is not sufficiently staffed to provide the needed or preferred care to patients. Further, the office environment has exacerbated a discernable level of staff turnover due to being worked hard for years from the busyness of the physician office practice.

The phenomena described by these participants regarding perceived busyness and the related concepts when considered comprehensively is cyclical in nature. The continuous characteristics of this cycle of caring for large volumes of patients, long waiting times for access, and long wait times at the visit challenge the practice. The office staff must function within confined spaces and among intrapersonal issues which place ongoing stress on the staff. Staff develop burnout and turnover thus leaving the practice to be perceived as having insufficient staff to provide the needed care for patients.

Developing relationships. Many participants described aspects of developing relationships with staff as enduring progressions which take time to evolve. Managing chronic illness requires commitment and investment by patients to seek ongoing healthcare services that provide the framework with which they maintain a degree of healthy living to the extent allowable. Ten of the 11 participants noted the duration of their relationship with the primary care physician as 20 years or more; thus, developing

relationships with the office staff is key to maintaining the patients' ongoing commitment as co-managers of their own health and continuing engagement with health care systems.

Multiple interactions between office staff and patients occur over a given period, and the volume of exchanges can contribute to the patients' satisfaction of the encounters. Every patient-staff encounter results in some degree of positive or negative outcomes. One participant expanded on developing relationships as she described a time when a referral did not occur as planned:

> (T), she and I had a little ... She messed something up ... They were sending me somewhere ... Well, I'm gonna keep the referral, but I'm not gonna go right away because I got too much going on. I'll let you know when I go. Well, she called and left a message, "Just wondering how you made out?" Twice. And twice, I called her and told ... So, she just wasn't as friendly as the rest of them, but now she is; I guess she just had to get to know me. Now, she's good. (11.0, p. 9)

Developing relationships is rooted in the patients' communications with staff. Participants described communication with staff which occurred in three primary modes; face to face interactions at the office, telephone encounters, and interacting with the staff via patient portals. Each modality resulted in positive and negative experiences with staff as narrated by participants in their perceptions of physician office staff. Participants' excerpts to illustrate the developing relationships phenomena are expressed for each staff communication modality.

Patient portals are secure online web-based sites which allow the patient to view aspects of their medical records, appointments, and billing activity. Patient portals are frequently used for online communication typically between the patient and office staff.

One participant illustrated her use of the portal as episodic when dealing with a health issue. She felt some sensitivity about her frequent calling and interpreted this as bothering the staff, so she decided to try the portal for convenience:

> So, we were going back and forth, like I said, my vertigo was not going away. ... Back, forth, back, forth. And she ... Boom. Right on top of it, all the time ... I didn't wanna have to keep calling and bugging them and having them call me back. So, I thought, I'll try this, and it worked. I just don't like to bother people. Nothing they said or did ... They're always ... I mean, their office staff, oh, they're fantastic. But I ... It was me. (11.0, p. 7-8)

This perception reflected the participant's decision to not call repeatedly and interact with office staff which she interpreted as adding to their workload by bothering them. This example highlighted the patient's perceptions of physician office staff stress and how this perception influenced the patient's health behaviors of seeking clinical guidance through an electronic portal instead of calling the office and speaking to staff. Shifting strategies of communicating with staff from repeated calling to using the portal positively influenced this patient's sense of developing relationships because she felt this was less bothersome for staff.

A second participant described her portal experience as very helpful in managing her chronic illness, which requires her to self-report her blood test results to the physician office daily. Once the results are received by the office, the vitals are checked, and they respond with any necessary medication adjustments back to the patient. This interaction is convenient for her busy lifestyle which often had resulted in difficulty calling the office and reaching a person. She described the back and forth portal interactions as "all the

time and that works awesome." (8.0, p. 3) This description suggested that developing a

relationship with staff via the patient portal is preferred for her daily communication and

chronic care needs.

This same participant described another scenario when her anxiety was

heightened due to a serious health condition which required her to frequently interact

with a neurologist's office. She described negative perceptions of communicating with

staff because of their lack of follow through in response to her repeated calls: "You want

to talk to a human being, you want to get, or you want to feel like you're you know,

someone is getting back to you. (8.0, p. 3)

Still another participant shared his perspective on developing relationships and

communicating with staff simply as, "They do a nice job there. Generally, what I get out

of it, I get back." (4.0, p. 5) His frame of mind compared to the prior example (8.0) of

heightened anxiety was one of a calm, easy-going status that underscored his approach of

communicating with staff.

A different perspective offered by a third participant denoted recognition of the

changing aspects of healthcare and the need to explore new methods of staff

communication such as the portal and personal care management:

They gave it to me one time, but before I got to it, it expired, the password

expired, whatever, and I couldn't get in and I haven't pursued it since then. I

should start using it more, because there's other doctors who also gave me a

portal. But I haven't used it. And I do need to. I think that would be the right way

to do it. That's the way it's going. But sometimes you can't interact with

somebody. I don't know if I can do that on a portal or not. Maybe I could, but ... I

don't know if I would know that with the portal or not, but I do have to start using

that and I will, eventually. (12.0, p. 8)

This exchange described both a willingness and an uneasiness to utilize a portal. His

perception suggested a preference for live staff communication rather than electronic

interactions with office staff to ensure an understanding of health service details and

expectations. This perception indicated the participant's preference for the personal

interaction and the human connection. Developing relationships with the office staff

enhances his own sense of comfort and establishes trust.

However, this next example provided a fourth participant's perceptions of

communicating with office staff as described from his phone call interactions:

Typically, they'll call and leave a message at home or leave a message at work,

and it's usually the nurse. I don't know them; I mean they are all polite and

everything. Anytime I've ever had to call back in years and years and years I've

never had a problem. (7.0, p.9)

This interpretation inferred that for years he has not experienced any communication

issues with staff, although he also stated that he does not know them. From his

perspective, no patient staff relationship has been developed. He elaborated on the

challenge of establishing a relationship with the office staff when prompted by the

question of how staff could improve upon assisting the patient with decisions and healthy

behaviors:

I go in and every once and awhile, I'll recognize a couple of the staff there. But

it's like oh, hi, hey you take blood a couple of times ago I don't remember. It's

not like oh, nurse Betty, nurse Bob how you doing, how's the family this that and

the other thing ... We want to increase the patient satisfaction, it goes back to the

doctor's office, how do they do it? I mean I understand you have your nurse

when you're an inpatient, you have your nurse and you see her for 20 minutes or

an hour or 3 hours or 4 hours all day long depending on your thing. So, you get

kind of a relationship. (7.0, p. 10,13)

This description exemplified the importance of having a personal connection with the

office staff and how this would influence patient satisfaction. This final excerpt from the

same participant accentuates the significance of developing relationships:

But it's like, for the next available nurse press 3, and whoever it is, that's who I'll

talk to. I don't go, I've been dealing with Betty or Bob for the last 10 years, can I

talk to them? Or Betty or Bob calls up the (patients) R – W's, the other calls A –

C's to get a relationship. It's whoever is there. (7.0, p. 9)

This description highlighted the patient's inability to establish a relationship with a staff

member as a result of office practice operations and processes. Staff interactions with

patients on the phone are a daily, nonstop process. Staff may answer a 100 phone calls a

day. For the staff, this experience is one-to-many, merely a function of their role. For

the patient, the phone call is a one-to-one experience based upon self-need. Office staff

processes have influenced him as he noted he has not developed relationships with one or

two primary office staff, rather speaking with whomever was there when he called the

office. Although he also stated: "How to get the message across to me that would take

effect from the staff level, probably more of that personal long-term connection."(7.0, p.

10) This description stressed the value of the patient-staff relationship and how this

influences his willingness to receive information or education from the staff as proxy to the physician about maintaining healthy habits.

The phenomenon of patients' ability to establish relationships with physician office staff is influenced and shaped by the ongoing communications with staff over the duration of the relationship. Patients interpreted their repeated contact and interactions with staff in several ways. Ongoing communication and inquiry are a necessity to ascertain the desired information or outcomes. If staff do not follow up on the patients' timeliness expectations, patients will repeatedly follow up to ensure they do not fall through the cracks of service. This was the described experience from a participant who was in a heightened state of anxiety due to complicating health issues she encountered.

A second interpretation which altered one patient's health seeking behavior is that her repeated calls were bothering the staff. Instead of continuing to make phone calls for assistance, she began communicating with staff on the patient portal which offered her prompt follow up from the staff and relieved her own sensitivity about bothering the staff.

A key concept of developing relationships is the patients' perceived ability to maintain ongoing communication not only with any staff, but preferably with a known staff member. This was expressed in terms of increasing patient satisfaction during the office experience as well as the participants' willingness to engage in health education with a trusted staff member.

Summary of Results

The interpreted data analysis of patients' perceptions of office staff stress revealed four primary categories: seeking connection, valuing human touch, perceiving busyness,

and developing relationships. Ongoing interactions with staff produced outcomes which either positively or negatively influence the patient–staff relationship. This relationship dynamic is comparable to the patient–physician relationship, which creates a working alliance that facilitates trust and communication thereby enhancing the patients' ability to understand the value of and greater ability to be compliant with treatment (Fuertes, 2007).

Patients similarly attribute value to the patient-staff relationship as staff serve as proxy to the physician. Managing chronic illness requires patients to endure long-term relationships with their healthcare team, which for many is the primary care physician and the physician office staff. Staff as proxy to the physician serve in a bridge role between the patient and physician which provides reassurance to the patient seeking connection. Patients need to experience trust, empathy, and compassion with their staff interactions. These elements of human touch have become compromised in complex environments of routinized systems and automation. Patients' perceived physician and staff busyness, experienced as the need for access, and interpreted interactions of staff stress as burnout, reduced staff levels, and staff turnover. These findings align closely with Harter et al's. (2002) meta-analysis confirming a relationship between employee satisfaction and business outcomes. This construct influences the patients' perceived ability to establish strong patient-staff relationships identified as an important attribute of feeling connected to their physician.

Chapter 5: Discussion

Introduction

The purpose of this qualitative study was to appreciate the patient perspective of the physician practice organizational climate to gain a deeper understanding of how complex factors surrounding organizational context, systems, and actors influence the patients' health behaviors. Patients with chronic illness account for the preponderance of every health care dollar spent in the United States, and 86% of healthcare spending is allocated to patients with one or more chronic conditions (Department of Health & Human Services, 2014). As ACA policies are transitioning patients with chronic illness from the hospital to physician office practices, it is incumbent upon healthcare leaders and providers to gain an appreciation of experiences from the patients' perspectives. This awareness will inform the development of mechanisms to bolster a complementary experience and enhance outcomes for patients with chronic illness.

The study findings discussed in Chapter 4 elaborate on the thematic construct of patients' perceptions of staff relationships. The four primary categories of patients' perceptions of physician office staff relationships are seeking connection, valuing human touch, perceiving busyness, and developing relationships. These categories evolved from the lived experiences described by the research participants and were interpreted to inform the thematic construct. Chapter 5 presents an emerging theoretical framework proposed to develop an understanding of the complex relationship dynamics experienced

between patients and physician office staff as translated by patients managing chronic illness.

Implications of Findings

Patients managing chronic illness are involved in long-term relationships with their primary care physicians (Fuertes, 2007). In many aspects, patients are dependent on their physicians for medical oversight, accessing specialty care physicians for the next level of care, navigating healthcare systems of testing, insurances, medications, as well as receiving education and wellness information. While healthcare policies are shifting patients from consumers of service to co-producers of their care (Coulter & Ellins, 2009), the primary care physician is the nucleus for the patient, and together they engage in the cycle of managing their chronic illness. Patients recognize that their primary care physician office staff are the link or bridge to accessing the physician. While there is no patient navigation handbook, there is recognition that patients' healthcare needs being successfully met by the physician are influenced by the physician office staff (Nembhard et al., 2015).

The responses were variable to research questions: R1 what are the patients' perceptions of physician office staff stress and R2 how the patients' perceptions of physician office staff stress influence patients' health seeking behaviors. The participants' perceptions covered a range of interpretations of staff stress. Two participants described their experiences with enough context that supports recognition of staff stress, but with varying influence on their health seeking behaviors. However, each participant experience originated from a different lens. One (11.0) noted that her repeated calls would bother staff contributing to staff stress; therefore, she adjusted her

means of communication from phone calls to use of the patient portal. The second (12.0) described his perspective that contributing factors of staff stress result from the complex healthcare environment which requires additional staff and expertise to navigate systems. In contrast, this participant did not describe influence of staff stress on his health seeking behaviors, although he did appreciate a need to adapt to changing technologies.

Research participants were asked to describe their overall health status and how this is going for them. Managing chronic illness requires the patient to be responsible for the day-to-day care over the length of the illness, a lifetime task (Lorig & Holman, 2003). Patients providing descriptions of their overall health and how this is going for them provides context and frames their state of mind. Paterson (2001) describes patients as having shifting mental statuses about their illnesses. Patients with chronic illness will shift between having illness or wellness in their psychological foreground. This shifting is partially due to the cyclical symptoms exacerbating or fading over the course of the chronic disease (Paterson, 2001). A patient's state of mind may influence one's perspective of physician office staff and the ability to establish relationships with staff proxy to the physician.

Patients' perceptions of physician office staff stress were identified and interpreted both as recognition of staff stress (bothering staff, environmental conditions, short staffed, staff turnover) and as recognition of the systems which influence the staff stress (office busyness, volumes of patients, frustrating processes) (Bronkhorst et al., 2015; Lemaire et al., 2018; Neuman et al., 2007). Patients managing chronic illness are in long-term relationships with their primary care physician and thus by proxy, the physician office staff. The patients' perceptions about seeking connection with the office

staff suggest the perceived significance of developing relationships with staff as a bridge to the physician.

Central to seeking connection and developing the patient-staff relationship is the patient's care experience of empathy, compassion, and trust (Nembhard et al., 2015; Neumann et al, 2007). The categories of seeking connection, valuing human touch, perceiving busyness, and developing relationships evolved from the lived experiences described by the research participants. An emerging conceptual model illustrating this framework is demonstrated in Figure 5.1.
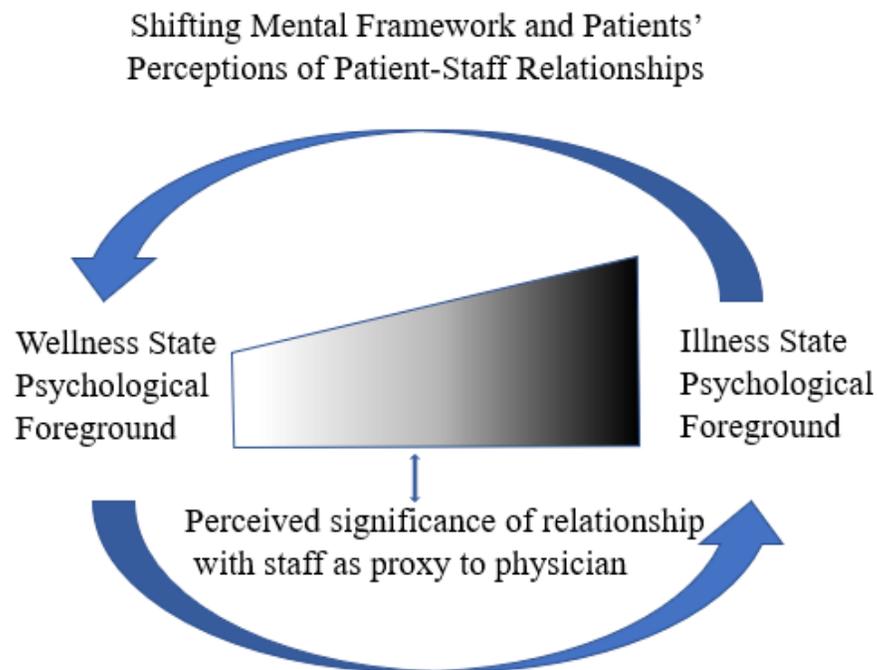

Shifting Mental Framework and Patients'
Perceptions of Patient-Staff Relationships

Wellness State
Psychological
Foreground

Illness State
Psychological
Foreground

Perceived significance of relationship
with staff as proxy to physician

Figure 5.1. Chronically Ill Patients' Perceived Relationships with Physician Office Staff
Note. Adapted from "The Shifting Perspectives Model of Chronic Illness," by B. Paterson, 2001, *Journal of Nursing Scholarship, 33, p. 23.* Copyright 2019 by John Wiley and Sons.

This conceptual model illustrates the phenomenon of how chronically ill patients' perceived relationships with physician office staff may fluctuate. Paterson (2001) described patients experiencing chronic illness as always changing in response to gained

perspectives of their illness and their ability to make sense of this. Perspectives of

chronic illness will determine how people respond to the disease and ones' greater life

experiences (Paterson, 2001). For patients with chronic illness, this shifting mental

model fluctuates between having wellness in the psychological foreground to having

illness in the psychological foreground.

As patient's shifting mental framework changes from one of wellness to illness on

the psychological foreground, their perceived significance of the relationship with staff as

proxy to physician also shifts. During the illness state, patients may experience more

heightened anxiety and a perceived threat to their overall control (Paterson, 2001). This

can lead to greater interactions or seeking connections with the office staff as proxy to the

physician. This effort may be to address the perceived threat to their control. When the

patient has wellness on the psychological foreground, the perceived significance of the

patient staff relationship is less intensified as the patient has in essence "bounced back"

with new perspectives or a sense of control of their chronic illness.

The participants' descriptions did suggest that a key component of the interactions

between themselves and office staff are the need to feel compassion, empathy and to

establish trust (Kowalski et al., 2009). Five of the 11 participants used one or more of

these three elements when describing their interactions, and a sixth participant

paraphrased descriptors of empathy. Compassion, empathy, and trust are the

foundational building blocks upon which human relationships are established and

maintained. A working alliance creates a partnership which facilitates trust and

communication, enhancing the patients' ability to understand the value of and greater

ability to be compliant with treatment (Fuertes, 2007). Patients managing chronic illness

together with their primary care physicians and office staff enter long standing partnerships to achieve the best possible outcomes for optimal living. Those partnerships in which the patients perceive, and experience compassion, empathy, and trust may influence a more complementary patient care experience and enhance outcomes for patients with chronic illness (Kowalski et al., 2009).

Limitations

This qualitative inquiry used GTM to focus on the patients' perspectives of physician office staff stress and the influence of these perceptions on the patients' health behaviors. Defining theoretical category saturation as light, moderate, and heavy; this study's saturation is light, with time as the limiting factor.

The research context was one of patients from two primary care physicians' offices located in a mid-sized urban region. Both practice locations are in zip codes considered more affluent in central New York Onondaga County. The zip code demographics range race from 89% - 94% white, with median household income between $64,192 - $70,854 (Zipdatamaps, 2019) which may have contributed to geographic skewing.

There is the potential that due to the primary care physicians introducing the study opportunity to their patients, that the patients who did choose to participate offered more positive feedback of their staff perceptions. The patients may have been concerned that negative feedback would influence their future care. Additionally, the researcher is an executive in the healthcare field and has personally experienced the studied phenomena; it is possible that bias has been introduced into the data coding, interpretation, and analysis processes of GTM.

Recommendations

Further research. This study design and methodology would benefit from expansion to include a larger number of research participants or use of focus groups to assess if similar perceptions exist among greater numbers of patients. Further study to assess perceptions of patients from lower socioeconomic status (SES) groups is indicated to determine how patients of lower SES experience similar phenomena at the primary care physician office. Additionally, gaining a deeper understanding of how the patients' perceptions of being lucky or fortunate influence making sense of their chronic illness and their shifting mental framework is suggested.

Policy development. The changes brought about by the ACA in 2010 have significantly influenced healthcare reform policies (Chokshi, Rugge, & Shah, 2014). Payment reform is often analyzed and debated. Organizational models and payment models in U.S. health care systems are broadly diverse (Guterman et al., 2009). As primary care physicians are taking on more accountability for care of chronically ill and complex patients, payment models should be adjusted to appropriately compensate the physicians' practices for this increased burden.

Hospitals are reimbursed for care based on a system of diagnosis related groups (DRG). Patients who require higher levels of care based upon severity of illness equate to DRGs which reimburse the hospital more for providing a higher intensity of care (Guterman et al., 2009). National and state policy development which support models of enhanced physician practice reimbursement to offset the cost of providing care to patients with chronic disease should be piloted.

Improved practice. In 2008, the Institute for Healthcare Improvement described the Triple Aim of healthcare as improving the patient experience of care, improving the health of populations, and reducing cost per capita for care (Whittington, Nolan, Lewis, & Torres, 2015). Recent literature devoted to understanding and improving the patient experience points to empathy and compassion as key aspects influencing the care experience (Donald et al., 2019; Lemaire, 2018; Vries et al., 2014). The successful patient-physician and patient-staff relationship are founded on the ability of the physician and staff to effectively demonstrate empathy and compassion.

This study suggests that chronically ill patients' perceptions of their relationships with staff as proxy to the physician is influenced by the patients' shifting mental framework. Additionally, these findings submit that patients perceive that office staff stress influences developing relationships with staff as proxy to the physician. Thus, two opportunities for improved practice are offered.

The first practice improvement is to identify strategies to reduce stressful situations in the physician office. Gaining an understanding of situational factors which trigger stress and developing appropriate response levers to help mitigate their influence is one approach. Recognizing the influence of organizational climate on the office environment is essential. Building team cohesiveness, improving communication, and promoting staff autonomy may help alleviate stressful practices. Staff who experience positive work environments engage in behaviors that facilitate positive customer experiences (Nembhard, 2015).

The second practice improvement is to ensure staff awareness of the influential partnership they enter with patients. Understanding the conceptual model of patient-staff

76

relationship with staff as proxy to the physician would provide insight to the vital role staff play for patients. Staff recognition of the shifting mental model theory of chronically ill patients and appreciation of their role in developing relationships with patients could positively support the patient care experience. Focused training should be provided for physicians' office staff to understand that patients' care experiences are influenced by their current health status. Staff who utilize a less business-like approach and recognize the patients' needs while providing customer service with empathy and compassion will bolster the vital patient-staff relationship and contribute to a positive care experience.

Conclusion

Healthcare in the United States continues to undergo a paradigm change in part resulting from several policies introduced as a result of the 2010 Affordable Care Act. Many of these policies are designed to address spiraling health care costs by shifting care from the high-cost, high-touch hospital setting to the lower-cost, lower-touch physician office (Chokshi, Rugge, & Shah, 2014). Concomitantly, chronic disease is on the rise in the United States and, as noted by the Centers for Disease Control and Prevention (2014), accounts for three of every four dollars spent on health care. A phenomenon coined the Silver Tsunami, aging population coupled with increasing chronic disease, declares baby boomers are becoming Medicare-eligible and entering primary care practices at a rate of 10,000 per day through 2029 (Social Security News Release, 2007). These parallel environmental conditions are creating new challenges as the burden of care transitions to the physician office setting.

These multiple factors are creating challenging environments within the primary care physician office practices. Schwartz (2012) describes similar challenges within these practices attributed to decreased office production and accelerated attrition, resulting in a declining physician primary care workforce. These factors are associated with negative working conditions in the physician office (Linzer et al., 2009) that contribute to a phenomenon of chaotic practices (Perez et al., 2017). Chaotic practices are characterized by increased patient flow bottlenecks, low work control, increased stress, burnout, and likelihood of leaving. These environmental conditions are contributing factors to poor organizational climate (OC), the interrelated experiences and meanings people share at work.

Empirical evidence of OC confirms the relationship between employee satisfaction and business outcomes (Harter et al., 2002). This meta-analysis supports employee satisfaction and engagement correlates to meaningful organizational outcomes generalizable across multiple business sectors. A literature review confirms recent empirical evidence which supports the influence of OC in the healthcare setting (Wolf et al., 2014; Kadu & Stolee, 2015; Vargas Bustamante et al., 2017). The primary research areas focus on OC in the healthcare environment and employee stress, the influence of OC and managing chronic illness, and the influence OC has on patient perceptions and outcomes.

Several studies cite the relevance of OC to knowledge-intensive service industries where creating value is critical (Bahrami et al., 2016; Carlucci & Schiuma, 2014; MacDavitt et al., 2007). This research supports the relationship of OC and employee satisfaction to organizational commitment among hospital RNs. Staff perceptions of OC

influence service quality, the ability to satisfy patients, productivity, and innovation. Further, factors of OC related to organizational pressure, support, and trust are positively associated with healthcare workers' self-efficacy while providing care in a chronic care setting (Karantzas et al., 2016).

Benzer et al. (2016) state the psychological themes such as empowerment and workload positively impact teamwork processes that support high performing teams which overall influence patient outcomes and quality in primary care offices. Dickinson et al. (2015) argue practice context (work culture, change culture, chaos) play a role in successful implementations of care models which support chronic care in the primary care setting. Vargas Bustamante et al. (2017) supports a positive association between favorable OC and improved chronic disease processes and management in the physician office setting.

Findings of a systematic review (Brathwaite et al., 2016) suggest the majority of studies assessed (74.2%) support that organizational and workplace cultures positively correlate with patient outcomes in the hospital, aged care facilities, and one community health center. Perez (2017) concludes that stressful practices are associated with adverse work conditions, dissatisfied physicians, and medical errors. When patients perceive physicians to be busy or overworked, they may alter their behaviors during the office visit to avoid overwhelming the physicians (Lemaire et al., 2018). Further, Saha et al. (2008) contend that lowered patient engagement in the patient-physician relationship diminishes relationship strength, which may influence the investment by both parties in following recommended treatment plans. Stenberg and Furness (2017) adopted a GTM to analyze the influence features of health trainers have on outcomes from the patient

perspective and why. The findings suggest the health trainers are perceived to contribute to patients living well through social connection, acceptance, and self-care.

Methodology. This study's purpose was to gain an understanding of the patients' perceptions of physician office staff stress and the influence these perceptions has on patients' health behaviors. Several theoretical models of behavioral and patient adherence constructs were assessed for applicability to this study. Some models demonstrate one or more elements germane to the study, though none reviewed accounted for the complexity of this phenomenon.

The theoretical elements which act as determinants of behavior modeled in Ajzen and Fishbein's (1975) theory of reasoned action (subjective norms, attitudes, and intention) and later in Ajzen's theory of planned behavior (subjective norms, attitudes, perceived control, and intention) offered some aspects of potential study framework. However, neither theory adequately demonstrates substantial relativeness in this context.

Other models considered included Rosenstock's health belief model and Hall and Fong's (2007) temporal self-regulation theory which demonstrate individual perceived benefits and barriers and the connectedness between actions and outcomes, respectively. Again, neither model accounts for a suitable study framework. Further models of social-cognitive behaviors related to health care and patient adherence were assessed for utilization, yet each one did not significantly frame the study context and complex

phenomenon of patients' perceptions of organizational climate. Therefore, GTM was selected for this study.

Specifically, this study analysis focuses on patients with chronic illness by asking the following research questions:

R1. What are the patients' perceptions of physician office staff stress?

R2. How do the patients' perceptions of physician office staff stress influence patients' health seeking behaviors?

The study design employs a qualitative GTM constructivist approach. GTM has broad applicability for social issues, practices, and events (Flick, 2014). Several studies utilizing GTM establish the applicability in researching chronic illness from the patient perspective (Charmaz, 2002; Charmaz, 2006; Charmaz, 2008). The GTM has applicability to assess chronically ill patients' perspectives of care in primary care physician offices. Charmaz (2014) maintains constructivists study how and sometimes why participants construct meaning and actions in specific situations, and researchers utilize reflexivity about their own interpretations and implications as well as those of the research participants in constructing conceptual models.

Patients identified with chronic illness from two primary care physician sponsors were provided contact information to participate in one-to-one purposive interviews. Eleven participants were interviewed with one patient requesting a second session for a total of 12 interviews. Open-ended questions (see Appendix A) grouped by theme (health status, health partnership, health management) were used to guide the interview flow; each session was recorded. Interview recordings were transcribed, each participant received copies of their transcribed sessions. No further comments were provided.

Data analysis. Each transcript was assessed through a step process of coding: open, axial, and selective. Constant comparative methodology shaped the inductive analysis of data comparison (Bryant et al., 2011). Researcher memos were recorded and transcribed immediately after each interview. Further memos and journaling throughout the coding process were utilized to enhance theory development (Flick, 2014). A theoretical model of patients' perceived relationships with physician office staff developed as a proposed visual demonstration of the analysis (Charmaz, 2014).

Major theme. Patients living with chronic illness are shifting into roles of co-managers and partners in long-term relationships of care with their primary care physicians and the office staff. This is occurring in parallel with major paradigm changes happening in healthcare that are designed to drive patients into the physicians' office and are resulting in increased complexity and systems of care.

Patients' perspectives of the physician practice inform their interpretation of overall busyness by observations of the physician, the staff, and by the volumes of patients receiving care. Reluctant to contribute to this busyness, patients may alter their health seeking behaviors. Developing and maintaining the patient-staff relationship is interpreted as an important aspect for the patients because patients perceive the staff as proxy to the physician. This working alliance supports the patients' link to their physician.

The patient-staff relationship is a valued component of the patients' sense of trust and experiences of empathy and compassion. Changes in patient's health status may cycle between periods of experiencing their personal sense of wellness or sense of illness in their psychological foreground. The major thematic conceptual model is one which

82

demonstrates that the patient perceives a greater significance of the patient-staff

relationship when experiencing illness on their psychological foreground than when

wellness is on their psychological foreground. Patients who have shifted across the cycle

of wellness to illness may have heightened expectations of staff in terms of

responsiveness and experiences of empathy and compassion.

References

Aarons, G. A., Ehrhart, M. G., Torres, E. M., Finn, N. K., & Beidas, R. S. (2017). The humble leader: Association of discrepancies in leader and follower ratings of implementation leadership with organizational climate in mental health. *Psychiatric Services*, *68*(2), 115–122. doi.org/10.1176/appi.ps.201600062

American Diabetes Association, (2018). Standards of care. *The Journal of Clinical and Applied Research and Education*. 41(1). Doi.org/10/2337/dc18-S006

Ajzen, I., & Fishbein, M., (1970). The prediction of behavior from attitudinal and normative variables. *Journal of Experimental Social Psychology, 6,* 466-487.

Bahrami, M. A., Barati, O., Ghoroghchian, M., Montazer-alfaraj, R., & Ranjbar Ezzatabadi, M. (2016). Role of organizational climate in organizational commitment: The case of teaching hospitals. *Osong Public Health and Research Perspectives*, *7*(2), 96–100. doi.org/10.1016/j.phrp.2015.11.009

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychology Review*, *84*(2), 191–215. doi.org/10.1111/1467-9280.00090

Benzer, J. K., Mohr, D. C., Evans, L., Young, G., Meterko, M. M., Moore, S. C., … Charns, M. P. (2016). Team process variation across diabetes quality of care trajectories. *Medical Care Research and Review*, *73*(5), 565–589. doi.org/10.1177/1077558715617380

Benzer, J. K., Young, G., Stolzmann, K., Osatuke, K., Meterko, M., Caso, A., … Mohr, D. C. (2011). The relationship between organizational climate and quality of chronic disease management. *Health Services Research*, *46*(3), 691–711. doi.org/10.1111/j.1475-6773.2010.01227

Braithwaite, J., Herkes, J., Ludlow, K., Lamprell, G., & Testa, L. (2016). Association between organisational and workplace cultures, and patient outcomes: Systematic review protocol. *BMJ Open*, *6*(12), 1–12. doi.org/10.1136/bmjopen-2016-013758

Brandes, K., & Mullan, B. (2014). Can the common-sense model predict adherence in chronically ill patients? A meta-analysis. *Health Psychology Review*, *8*(2), 129–153. doi.org/10.1080/17437199.2013.820986

Bronkhorst, B., Tummers, L., Steijn, B., & Vijverberg, D. (2015). Organizational climate and employee mental health outcomes: A systematic review of studies in health care organizations. *Health Care Management Review*, *40*(3), 254–271. doi.org/10.1097/HMR.0000000000000026

Brown, R., Dunn, S., Byrnes, K., Morris, R., Heinrich, P., & Shaw, J. (2009). Doctor's stress responses and poor communication performance in simulated bad news consulations. *Academic Medicine*, *84*(11), 1595–1602. doi.org/10.1097/ACM.0b013e3181baf537

Bryant, A., Casper, M., Charmaz, K., Henwood, K., Mitchell, R. G., Clarke, A., … Charmaz, K. (2011). *Introduction: grounded theory research: methods and practices in: The SAGE handbook of grounded theory.*doi.org/10.4135/9781848607941

Carlucci, D., & Schiuma, G. (2014). Organizational climate as performance driver: Health care workers' perception in a large hospital. *Journal of Health Management*, *16*(4), 583–594. doi.org/10.1177/0972063414548561

Centers for Disease Control and Prevention. (2014). *Chronic disease prevention and health promotion.* Retrieved from https://www.cdc.gov/chronicdisease/about/costs/index.htm

Charmaz, K. (2002). Stories and silences: Disclosures and self in chronic illness. *Qualitative Inquiry*, *8*(3), 302–328. doi.org/10.1177/107780040200800307

Charmaz, K. (2006). Measuring pursuits, marking self: Meaning construction in chronic illness. *International Journal of Qualitative Studies on Health and Well-Being*, *1*(1), 27–37. doi.org/10.1080/17482620500534488

Charmaz, K. (2008). Views from the margins: Voices, silences, and suffering. *Qualitative Research in Psychology*, *5*(1), 7–18. doi.org/10.1080/14780880701863518

Charmaz, C. (2014). *Constructing grounded theory.* London: Sage.

Chokshi, D., Rugge, J., & Shah, N. (2014) Redesigning the regulatory framework for ambulatory care services in New York. *The Milbank Quarterly, 92*(4) 776-795

Coulter, A., & Ellins, J. (2009). Changing attitudes to the role of patients in health care. In S. Newman, L. Steed, & K. Mullian (Eds.), *Chronic physical illness: Self-management and behavioural interventions* (pp. 28-44). Maidenhead, UH: Open University Press.

Cox, C. (1982). An interaction model of client health behavior: Theoretical prescription for nursing. *Advances in Nursing Science*, *5*, 41–56.

Department of Health & Human Services U.S.A., Agency for Healthcare Research and Quality. (2014). *Multiple Chronic conditions Chartbook* (Publications No. Q14-0038). Washington, DC: Government Printing Office.

Dickinson, L. M., Dickinson, W. P., Nutting, P. A., Fisher, L., Harbrecht, M., Crabtree, B. F., … West, D. R. (2015). Practice context affects efforts to improve diabetes care for primary care patients: A pragmatic cluster randomized trial. *Journal of General Internal Medicine*, *30*(4), 476–482. doi.org/10.1007/s11606-014-3131-3

Dimatteo, M. R., Haskard-Zolnierek, K. B., & Martin, L. R., (2012). Improving patient adherence: a three-factor model to guide practice. *Health Psychology Review*, *6*, 74–91. doi.org/10.1080/17437199.2010.537592

Donald, G., Wilson, I., Mccarthy, J., Hall, I., Crossley, B., Adshead, P., … Dwyer, T. (2019). Experiences of nurses and other health workers participating in a reflective course on compassion-based care. *British Journal of Nursing*, *28*(15), 1020–1026.

Dunbar, J. (1980). Adhering to medical advice: A review. *International Journal of Mental Health*, *9*(1), 70-87.

Ebrahimi, E., Sadeghian, N., Seyedfatemi, N., Mohammadi, E., (2017). Chronic patients' autonomy in Iranian hospitals: A qualitative study. *Ethics & Behavior, 27*(1), 74-87.

Einarsen, S., Hoel, H., Zapf, D. & Cooper, C. (Eds.). (2003) *Bullying and emotional abuse in the workplace.* London: Taylor and Francis.

Flick, U. (2014). Grounded theory coding. In K. Metzler, et al., (Eds.), *An introduction to qualitative research* (5th ed., pp. 399). Thousand Oaks, CA: Sage.

Friedberg, M. W., Rodriguez, H. P., Martsolf, G. R., Edelen, M. O., & Bustamante, A. V. (2016). Measuring workplace climate in community clinics and health centers. *Medical Care*, *54*(10), 944–949. doi.org/10.1097/MLR.0000000000000585

Fuertes, J. N., Boylan, L. S., & Fontanella, J. A. (2007). Behavioral indices in medical care outcome: The working alliance, adherence, and related factors. *Journal of General Internal Medicine*, *24*(1), 80–85. https://doi.org/10.1007/s11606-008-0841-4

Glisson, C., & Green, P. (2011). Organizational climate, services, and outcomes in child welfare systems. *Child Abuse and Neglect*, *35*(8), 582–591. doi.org/10.1016/j.chiabu.2011.04.009

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect*, *22*(5), 401–421. doi.org/10.1016/S0145-2134(98)00005-2

Glisson, C., Landsverk, J., Schoenwald, S., Kelleher, K., Hoagwood, K. E., Mayberg, S.,
… Palinkas, L. (2008). Assessing the organizational social context (OSC) of mental
health services: Implications for research and practice. *Administration and Policy in
Mental Health and Mental Health Services Research*, *35*(1–2), 98–113.
doi.org/10.1007/s10488-007-0148-5

Green, A. E., Albanese, B. J., Cafri, G., & Aarons, G. A. (2014). Leadership,
organizational climate, and working alliance in a children's mental health service
system. *Community Mental Health Journal*, *50*(7), 771–777.
doi.org/10.1007/s10597-013-9668-5

Guest, G., Bunce, A., Johnson, L. (2006). How many interviews are enough?: An
experiment with data saturation and variability. *Field Methods, 18*(1), 59-82.
doi:10.1177/1525822X05279903

Gulliver, A., Griffiths, K., Christensen, H., & Brewer, J.L. (2012). A systematic review
of help-seeking interventions for depression, anxiety and general psychological
distress. *BMC Psychiatry, 12*, 81.

Guterman, S., Davis, K., Schoenbaum, S., & Shih, A. (2009). Using medicare payment
policy to transform the health system: A framework for improving performance.
Health Affairs, *28*(2), 238–251. doi.org/10.1377/hlthaff.28.2.w238

Hall, P. A., & Fong, G. T. (2007). Temporal self-regulation theory: A model for
individual health behavior. *Health Psychology Review*, *1*(1), 6–52.
doi.org/10.1080/17437190701492437

Hankins, M., French, D., & Horne, R., (2000). Statistical guidelines for studies of the
theory of reasoned action and the theory of planned behavior. *Psychology and
Health, 15,* 151-161

Harter, J. K., Schmidt, F. L., & Hayes, T. L. (2002). Business-unit-level relationship
between employee satisfaction, employee engagement, and business outcomes: A
meta-analysis. *Journal of Applied Psychology*, *87*(2), 268–279.
doi.org/10.1037//0021-9010.87.2.268

Health Consumer Powerhouse. (2015). *Euro Health Consumer Index 2014*(5).
doi.org/ISBN 978-91-977879-9-4

Hellriegel, D., & Slocum, J. W. (1974). Organizational climate: measures, research and
contingencies. *Academy of Management Journal*, *17*(2), 255–280.
doi.org/10.2307/254979

Horne, R., Chapman, S. C. E., Parham, R., Freemantle, N., Forbes, A., & Cooper, V.
(2013). Understanding patients' adherence-related beliefs about medicines

prescribed for long-term conditions: A meta-analytic review of the necessity-concerns framework. *PLoS ONE, 8*(12). doi.org/10.1371/journal.pone.0080633

Horne, R., Weinman, J., Barber, N., & Elliott, R. (2005). Concordance, adherence and compliance in medicine taking. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). *National Co-Ordinating Centre for NHS Service Delivery and Organisation R & D*, 1–331. doi.org/10.1007/SpringerReference_64584

Husdal, R., Rosenblad, A., Leksell, J., Eliasson, B., Jansson, S., Jerdén, L., … Thors Adolfsson, E. (2018). Resources and organisation in primary health care are associated with HbA1clevel: A nationwide study of 230 958 people with Type 2 diabetes mellitus. *Primary Care Diabetes, 12*(1), 23–33. doi.org/10.1016/j.pcd.2017.09.003

Janz, N., & Becker, M. (1984). The health belief model: A decade later. *Health Education Quarterly, 11,* 1-47

Kadu, M. K., & Stolee, P. (2015). Facilitators and barriers of implementing the chronic care model in primary care: a systematic review. *BMC Family Practice, 16*, 12. doi.org/10.1186/s12875-014-0219-0

Karantzas, G. C., McCabe, M. P., Mellor, D., Von Treuer, K., Davison, T. E., O'Connor, D., … Konis, A. (2016). Organizational climate and self-efficacy as predictors of staff strain in caring for dementia residents: A mediation model. *Archives of Gerontology and Geriatrics, 66*, 89–94. https://doi.org/10.1016/j.archger.2016.05.006

Kelley, M. (2005). Limits on patient responsibility. *Journal of Medicine and Philosophy, 30*(2), 189–206. doi.org/10.1080/03605310590926858

Kowalski, C., Nitzsche, A., Scheibler, F., Steffen, P., Albert, U. S., & Pfaff, H. (2009). Breast cancer patients' trust in physicians: The impact of patients' perception of physicians' communication behaviors and hospital organizational climate. *Patient Education and Counseling.* doi.org/10.1016/j.pec.2009.09.003

Kramer, T. L., Drummond, K. L., Curran, G. M., & Fortney, J. C. (2018). Assessing culture and climate of federally qualified health centers: A plan for implementing behavioral health interventions. *Journal of Health Care for the Poor and Underserved, 28*(3), 973–987.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping.* New York, NY: Springer

Lemaire, J. B., Ewashina, D., Polachek, A. J., Dixit, J., & Yiu, V. (2018). Understanding how patients perceive physician wellness and its links to patient care: A qualitative study. *PLoS ONE*, *13*(5), 1–15. doi.org/10.1371/journal.pone.0196888

Lorig, K. R., Holman, H. R., & Med, A. B. (2003). Self-management education : history, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine*, *1*(26), 1–7.

Linzer, M., Manwell, L. B., Williams, E. S., Bobula, J. a, Brown, R. L., Varkey, A. B., … Schwartz, M. D. (2009). Improving patient care working conditions in primary care : Physician reactions and care quality. *Annals of Internal Medicine*, *151*(1), 28–36, doi.org/10.7326/0003-4819-151-1-200907070-00006

MacDavitt, K., Chou, S.-S., & Stone, P. (2007). Organizational climate and health care. *Joint Commission on Accreditation of Healthcare Organizations*, *33*(11), 45–56.

McEachan, R. R. C., Conner, M., Taylor, N. J., & Lawton, R. J. (2011). Prospective prediction of health-related behaviours with the theory of planned behaviour: A meta-analysis. *Health Psychology Review*, *5*(2), 97–144. doi.org/10.1080/17437199.2010.521684

Morrison, E. W., Wheeler-Smith, S. L., & Kamdar, D. (2011). Speaking up in groups: A cross-level study of group voice climate and voice. *Journal of Applied Psychology*, *96*(1), 183–191. doi.org/10.1037/a0020744

Nembhard, I. M., Yuan, C. T., Shabanova, V., & Cleary, P. D. (2015). The relationship between voice climate and patients' experience of timely care in primary care clinics. *Health Care Management Review*, *40*(2), 104–115. doi.org/10.1097/HMR.0000000000000017

Neumann, M., Wirtz, M., Bollschweiler, E., Mercer, S. W., Warm, M., Wolf, J., & Pfaff, H. (2007). Determinants and patient-reported long-term outcomes of physician empathy in oncology: A structural equation modelling approach. *Patient Education and Counseling*, *69*(1–3), 63–75. doi.org/10.1016/j.pec.2007.07.003

Paterson B. (2001). The shifting perspective model of chronic illness. *Journal of Nursing Scholarship*, *33*(1), 21–26. doi/pdf/10.1111/j.1547-5069.2001.00021.x

Perez, H. R., Beyrouty, M., Bennett, K., Manwell, L. B., Brown, R. L., Linzer, M., & Schwartz, M. D. (2017). Chaos in the clinic: Characteristics and consequences of practices perceived as chaotic. *Journal for Healthcare Quality*, *39*(1), 43–53. doi.org/10.1097/JHQ.0000000000000016

Rich, A., Brandes, K., Mullan, B., & Hagger, M. (2015). Theory of planned behavior and adherence in chronic illness: A meta-analysis. *Journal of Behavioral Medicine, 38,* 673-688. doi: 10.1007/s10865-015-9644-3

Rosenstock, I.M. (1974) The health belief model and preventive health behavior. *Health Education Monographs, 2,* 354-386.

Saha, S., Freeman, M., Toure, J., Tippens, K. M., Weeks, C., & Ibrahim, S. (2008). Racial and ethnic disparities in the VA health care system: A systematic review. *Journal of General Internal Medicine*, *23*(5), 654–671. doi.org/10.1007/s11606-008-0521-4

Schein, E. H. (1984). Coming to a new awareness of organizational culture. *Sloan Management Review*, *25*(2), 3.

Schneider, B., Ehrhart, M. G., & Macey, W. H. (2013). Organizational climate and culture. *Annual Review of Psychology*, *64*(1), 361–388. doi.org/10.1146/annurev-psych-113011-143809

Schneider, B., González-Romá, V., Ostroff, C., & West, M. (2016). Organizational climate and culture: Reflections on the history of the constructs in journal of applied psychology. *Journal of Applied Psychology*, *(In Press)* (12), 468–482. doi.org/10.1037/apl0000090

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

Social Security News Release. (2007, October) *Nation's first baby boomer files for social security retirements benefits – online!* Retrieved from https://www.ssa.gov/news/press/releases/2007/#10-2007-2.

Stenberg, N., & Furness, P. J. (2017). Living well with a long-term condition: service users' perspectives of a self-management intervention. *Qualitative Health Research*, *27*(4), 547–558. doi.org/10.1177/1049732316628834

Streubert, H., & Carpenter, D., (2010). *Qualitative research in nursing: Advancing the humanistic imperative (5th ed.).* New York, NY: Lippincott Williams & Wilkins.

Sutton, J., Family, H. E., Scott, J. A., Gage, H., & Taylor, D. A. (2016). The influence of organisational climate on care of patients with schizophrenia: a qualitative analysis of health care professionals' views. *International Journal of Clinical Pharmacy*, *38*(2), 344–352. doi.org/10.1007/s11096-016-0247-z

United States Census Bureau, Quickfacts Onondaga County, New York. https://www.census.gov/quickfacts/fact/table/onondagacountynewyork/PST045217

Vargas Bustamante, A., Martinez, A., Chen, X., & Rodriguez, H. P. (2017). Clinic workload, the quality of staff relationships and diabetes management in community

90

health centers catering to Latino and Chinese patients. *Journal of Community Health*, *42*(3), 481–488. doi.org/10.1007/s10900-016-0280-9

Vries, A. M. M. De, Roten, Y. De, Meystre, C., Passchier, J., Despland, J., & Stiefel, F. (2014). Clinician characteristics, communication, and patient outcome in oncology a systematic review. *Psycho-Oncology*, *381*(November 2013), 375–381.

Wagner, E., Austin, B., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs*, *20*, 64–78.

Whittington, J., Nolan, K., Lews, N., & Torres, T. (2015). Pursuing the triple aim: The first 7 years. *The Milbank Quarterly*, *93*(2), 263–300.

Williams, N. J., & Glisson, C. (2014). Testing a theory of organizational culture, climate and youth outcomes in child welfare systems: A United States national study. *Child Abuse and Neglect*, *38*(4), 757–767. doi.org/10.1016/j.chiabu.2013.09.003

Willis, E. (2016). Patients' self-efficacy within online health communities: facilitating chronic disease self-management behaviors through peer education. *Health Communication*, *31*(3), 299–307. doi.org/10.1080/10410236.2014.950019

Wolf, D. A. P. S., Dulmus, C. N., Maguin, E., & Cristalli, M. (2014). Do organizational culture and climate matter for successful client outcomes? *Research on Social Work Practice*, *24*(6), 670–675. doi.org/10.1177/1049731513506616

World Health Organization. (2014). Chronic disease and health promotion. Retrieved from http://www.who.int/chp/action/en

ZipDataMaps. (2019). Zip codes in Onondaga county NY. Retrieved from https://www.zipdatamaps.com/onondaga-ny-county-zipcodes

<div align="center">**Appendix**</div>

<div align="center">Data Collection Interview Questions</div>

Health Status

1. Please start by telling me about your overall health.

2. How is this going for you?

Health Partnership

3. How long have you been a patient in this practice, or a patient of Dr. X.?

4. Do you go to your doctor visits by yourself or with someone?

5. When you contact (call/email) the office, who do you usually want to talk to? Why?

6. Who do you usually speak with and what happens?

Health Management

7. How have you learned about keeping yourself healthy?

8. Who has helped you learn about keeping yourself healthy?

9. Do you feel you have a good understanding of the instructions given to you? Did/Do you ask more questions? Why?

10. Describe something that the staff could do to help you feel more able to keep yourself healthy? Why?

11. Anything else you would like to share we didn't cover?