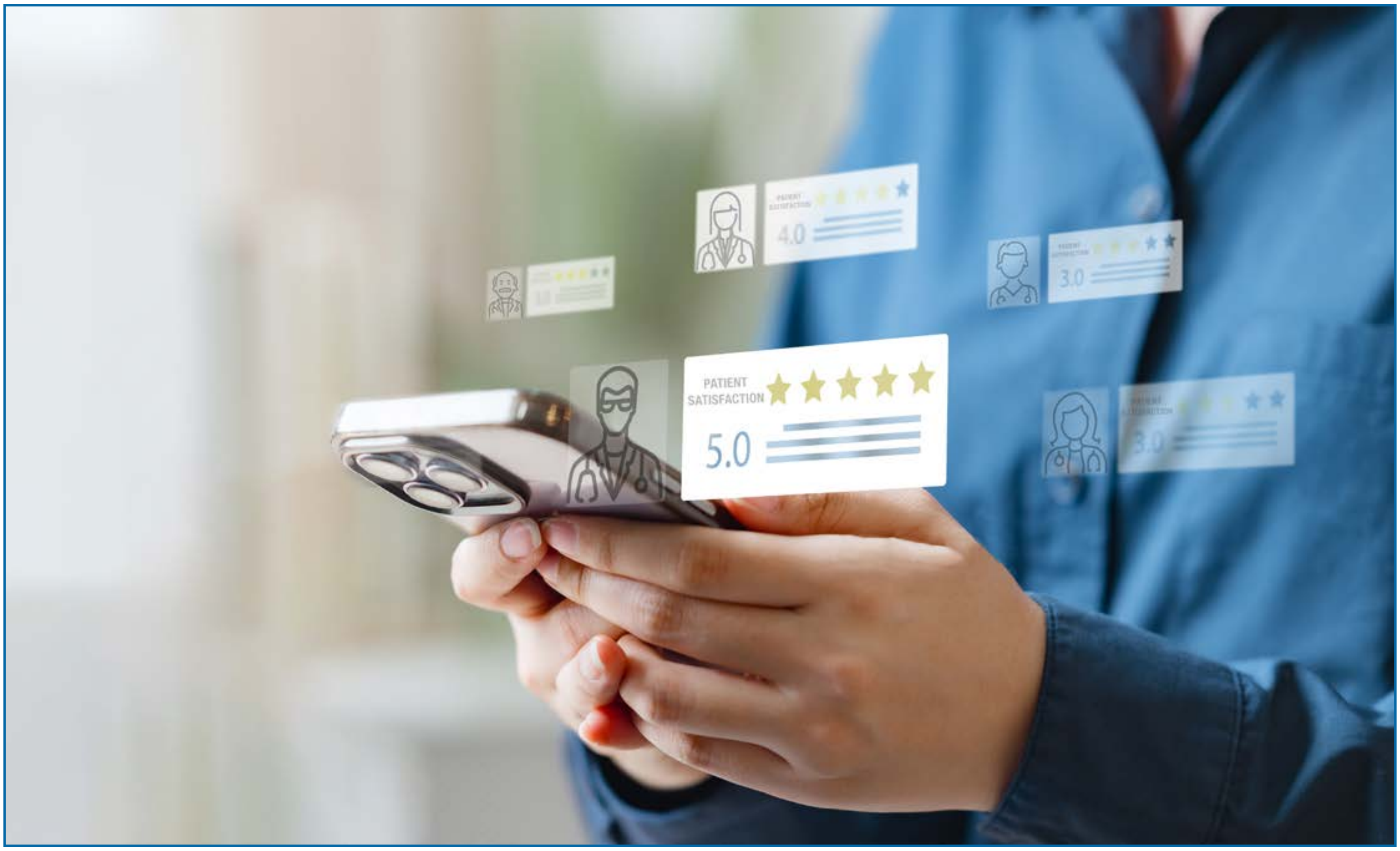
Family Doctor

A Journal of the New York State Academy of Family Physicians

NEW YORK STATE ACADEMY *of* FAMILY PHYSICIANS

Winter 2026
Volume fourteen, Number three



Focus:

Improving the Patient Experience

FEATURE ARTICLES:

- Getting to Inbox Zero: Real Life Strategies for Managing the Digital Side of Family Medicine
- Where's Amy?: A Look Into the Physician - Pharmacist Co-Visit Model
- Reclaiming Connection: How Direct Primary Care Transforms the Patient Experience While Preserving Physician Autonomy and Well-being
- The Waiting Game: Delays in Primary Care Access and Their Ripple Effects Across Generations
- Enhancing Patient Experience with Continuity of Care and Agile Technology

Family Doctor: A Journal of the New York State Academy of Family Physicians is published quarterly. It is an online only journal and members are eligible for CME credit through the AAFP.

New York State Academy of Family Physicians
99 Washington St., Suite 402
Albany, New York 12210
www.nysafp.org
Phone: 518-489-8945
Fax: 518-888-7648

Letters to the Editor, comments or articles can be submitted by email to penny@nysafp.org

Editor: Penny Ruhm, MS

Staff
Executive Vice President:
Vito Grasso, MPA, CAE vito@nysafp.org
Director of Education:
Kelly Madden, MS kelly@nysafp.org
Director of Finance:
Donna Denley, CAE donna@nysafp.org
Journal Editor:
Penny Ruhm, MS penny@nysafp.org

For Advertising Information
Contact Vito Grasso at 518-489-8945
or vito@nysafp.org

Articles

Departments

Index of Advertisers

From the Executive Vice President

By Vito Grasso, MPA, CAE

Improving patient experience is a constant challenge for everyone associated with healthcare. The problem is enormous as evidenced by the following data:

- Healthcare costs in the U.S. reached $4.9 trillion in 2023, accounting for 17.6% of the GDP, and are projected to reach $8.6 trillion by 2033. The U.S. spends more per capita ($14,570) on healthcare than other developed countries.
- A significant portion of spending is due to high administrative costs for both payers and providers.
- The U.S. pays higher prices for healthcare services, pharmaceuticals, and medical equipment compared to other countries.
- As the population ages, the total cost of healthcare is expected to increase.
- High salaries for physicians, higher administrative costs for insurance companies, and higher earnings for registered nurses contribute to overall costs.
- Despite the high spending, the U.S. does not consistently achieve superior health outcomes compared to its peers. Delays in accessing care is among the most common concerns articulated by patients. Workforce shortages and distribution of clinicians exacerbate access issues.
- In 2024, about 92% of Americans had health insurance for at least part of the year, which is 310 million people. Of the insured population, 66.1 % had private coverage and 35.5% had public coverage, with employment-based insurance being the most prevalent type.

  Most common types:
    Employment-based insurance: 53.8%
    Medicare: 19.1%
    Medicaid: 17.6%
    Direct purchase: 10.7%
    TRICARE: 2.8%
    VA and CHAMPVA: 1.2%

Much of this data suggests that the patient's experience in health care is inextricably tied to consistent failure of market forces in health care to account for the most fundamental of patient needs: access to quality care in a variety of care settings.

Assurance that patients will have the care they need to maintain or restore health has been constrained by the conflicting interests of payers, burgeoning health systems and government.

Payers and health systems are increasingly consolidating and have become bottom-line focused. The need for profit, regardless of corporate status, has subordinated patient needs and elevates cost-control practices which delay and frustrate access to care.

Government regulation is driven by political decisions which are further compromised by disproportionate political influence of payers and health systems over patient interests.

continued on page 4

> *NYSAFP has promoted single payer health care after careful consideration of options to improve our health care system.*

continued from page 3

NYSAFP has promoted single payer health care after careful consideration of options to improve our health care system. A single payer system, with government providing both the funding and the administrative system, offers the best and most reasonable option for prioritizing patient interests in designing and supporting a health care system. Proponents of single payer health care have argued that prior authorization and other administrative practices designed to protect payer profits consume a substantial portion of health care spending. A single payer system would eliminate this waste. The savings could be reinvested in expanding the workforce, research to create better treatment options, incorporating new technologies and other improvements designed to enhance patient experience.

Another major flaw in the current health care system is the separation of mental health care and primary care. NYSAFP and our Foundation are attempting to address this issue by forming a coalition to advocate for integration of mental health care and primary care. Fragmentation of the current system, difficulty inherent in achieving integration and the cost of doing so combine to make it unlikely this major problem will ever be addressed without wholesale restructuring of healthcare. Our efforts to begin aggressive and coordinated advocacy for integration of mental health care and primary care will continue March 12, 2026 when we convene a meeting and discussion of thought leaders we feel can help.

Efforts to improve the patient experience have been frustrated by the competing interests of major players of the current system. Until that system is replaced, we are unlikely to have reforms that will truly transform our system into the patient-centered system we have aspired to.

Upcoming Events

2026

Winter Cluster
February 22, 2026

Board Meeting
Renaissance Albany

Commissions Meet
Virtually Prior

Advocacy Day
Albany
February 23, 2026

Fundraiser: Great Minds for Mental Health
Uniondale
March 12, 2026

Congress of Delegates Convenes Virtually
Opening Session
May 9, 2026

Congress of Delegates Reconvenes at the Desmond Hotel
May 16-17, 2026

Albany Report

By Reid, McNally & Savage

December 17, 2025

The 2026 NYS legislative session will begin on Wednesday, January 7th in Albany and will run through June 4th. On January 13th, Governor Kathy Hochul will unveil her 2026 State of the State Address identifying her leading priorities for the year and the Governor is expected to release her SFY 2026-27 Executive Budget by January 20th.

Our firm has been working with NYSAFP to gear up for the new year and new session. Below is a summary of recent advocacy successes and efforts for NYSAFP and priorities that we will continue to work to address this year. We have also included a summary of 2025 state election results and recent actions taken by Governor Hochul on health-related legislation that passed both houses in 2025.

NYSAFP Advocacy Works

Medical Aid in Dying Act (MAID) To Be Passed and Signed into Law in January 2026

Following continuous grassroots advocacy, public relations activities, and collaborative work with the New York Alliance for Medical Aid in Dying, we are beyond happy to share that Governor Hochul reached an agreement with the State Legislature in mid-December to pass, with agreed-upon amendments, and sign MAID at the start of the 2026 NYS legislative session. Amendments, which when initially proposed by the Governor in early December were more comprehensive and burdensome for patients interested in utilizing MAID, and include the following:

- A mandatory waiting period of 5 days between when a prescription is written and filled.
- An oral request by the patient for medical aid in dying must be recorded by video or audio.
- A mandatory mental health evaluation of the patient seeking medical aid in dying by a psychologist or psychiatrist.
- A prohibition against anyone who may benefit financially from the death of a patient from being eligible to serve as a witness to the oral request or an interpreter for the patient.
- Limiting the availability of medical aid in dying to New York residents.
- Requiring that the initial evaluation of a patient by a physician be in person.
- Allowing religiously-oriented home hospice providers to opt out of offering medical aid in dying.
- Ensuring that a violation of the law is defined as professional misconduct under the Education Law.
- Extending the effective date of the bill to six months after signing to allow the Department of Health to put into place regulations required to implement the law while also ensuring that health care facilities can properly prepare and train staff for compliance.

continued on page 6

continued from page 5

We are also proud that the Governor's office invited NYSAFP to join the media event she hosted on December 17, 2025 in New York City announcing this development (with NYSAFP President Dr. Doucet and Dr. Paladine attending). We greatly appreciate membership's long-standing participation on this key priority with over 70 members recently sending grassroots letters to the Governor urging her to sign the legislation. As the Academy pivots toward assisting during the implementation phase in partnership with members of the MAID Alliance, NYSAFP members will be kept up-to-date with guidance and any relevant information.

Wrongful Death Bill Vetoed by Governor Hochul

Thanks to strong opposition from NYSAFP, partners in medicine as well as hospitals, insurers and others, a fourth version of the "wrongful death" bill passed by the Legislature in June was again vetoed by Governor Hochul on December 5th. Efforts included NYSAFP's outreach and members' grassroots letters to the Governor asking her to again veto the bill with 60 messages sent out cumulatively over the last months. This advocacy clearly registered strong opposition, as in her veto message she noted the higher costs that patients and consumers would likely face as a result of the changes proposed as well as the affordability crisis and increased financial stress to our healthcare systems. Thank you to the full membership for your strong efforts that contributed to this positive outcome.

Ongoing Advocacy

Vaccine Advocacy: In August of 2025, NYSAFP leadership met with State Health Commissioner McDonald and the Medical Directors for the NYS Department of Health (NYSDOH) Division of Vaccine Excellence (DOVE). We discussed our strong concerns with the now unreliable ACIP committee and recommendations, along with our recommendations for New York to create a statutory alternative to ACIP in NYS and to strengthen NY's adult vaccine registry by moving to an opt-out reporting system as opposed to the current opt-in that is currently required for patients. Finally, we discussed our strong support for NY to pursue public purchase of vaccines given the financial and other obstacles facing providers and patients in accessing expensive vaccines.

In response, Dr. McDonald said he shared our support for public purchase of vaccines which worked well in Rhode Island when he established it there. It was funded through a tax or surcharge on health insurers. Dr. McDonald noted that it could take multiple years to accomplish this in NY especially in light of new restrictions from CMS that states cannot establish new health insurer taxes and must phase out some of those that are currently in place. The Commissioner also said he was very supportive of mandatory reporting of adult vaccines to NYSIIS, similar to child vaccines and noted NYSDOH support for the pending legislation which has been stuck in the Senate that NYSAFP has led the advocacy effort on.

Finally, regarding the serious ACIP concerns which NYSDOH shares, Dr. McDonald mentioned that they are meeting regularly both internally and with neighboring states to identify ways to address the unreliability of ACIP. He said we should expect a series of state announcements and guidance to be rolled out in the coming months in response. In September, Governor Hochul as part of the Northeast Public Health Collaborative issued Covid-19 vaccine guidance for New Yorkers and announced NY's deference to the recommendations of AAFP, AAP and ACOG. The Northeast Public Health Collaborative is a voluntary group of regional public health agencies and leaders from several states and municipalities, including New York, New Jersey, Pennsylvania, Massachusetts, Connecticut, Maine, and Rhode Island. In September 2025, Governor Hochul and NYS Department of Financial Services (DFS) Superintendent Harris also reminded insurers of their obligation to cover without copays. Further, earlier this month, Governor Hochul signed an Executive Order allowing pharmacists to prescribe and administer COVID vaccines, ensuring continued access for all New Yorkers who wish to be vaccinated.

Looking Forward

We have seen multiple bills introduced this fall in an effort to address the need for statutory and regulatory alternatives to ACIP in NYS and we are anticipating a proposal in the Governor's budget to be released in January. NYSAFP will continue to advocate for states like NY to follow the national vaccination guidelines of AAFP and its other partners in medicine as alternatives to ACIP.

Additionally, NYSAFP and RMS continue to lead a vaccine coalition in New York (Let's Get Immunized NY) to help support education and advocacy around immunizations for children and adults and have been working diligently to ensure vaccine access and coverage in NYS given recent uncertainty with federal vaccine changes. LGINY hosted the State Health Commissioner at a coalition meeting in November and the discussion was informative and went very well. He shared that DOH supports medical assistants giving vaccines and moving New York to a universal vaccine state, but noted that this would not be possible in the near term due to the federal HR1 bill's insurance provider tax restrictions since this is how it has been financed in other states. He urged that groups and individuals can help by continuing to be vocal about recommended vaccination publicly as well as in the community and one-on-one/ patient conversations. NYSAFP will submit testimony for the 2026 State Health Budget Hearing emphasizing our vaccine priorities. Further, in late November LGINY sent a sign-on letter to Governor Hochul in support of key vaccine-related priorities and investments for inclusion/consideration in her Executive Budget.

continued on page 7

continued from page 6

Reproductive & Gender-Affirming Care and Shield Laws: NYSAFP has been working among a coalition including the New York Civil Liberties Union, Planned Parenthood of Greater New York, the Abortion Coalition for Telemedicine Access (ACT), and others to enhance New York's shield laws protecting abortion and gender-affirming care. We are happy to share that sources in Governor Hochul's administration are reporting that she will sign the Shield Law 2.0 bill which was a key legislative priority on the Academy's Advocacy Day in February 2025. The legislation amends several areas of law to prevent the state from engaging with hostile actors attempting to restrict access to reproductive health care and gender-affirming care. It would also build on professional discipline and medical malpractice protections in New York's shield laws by extending these to more providers that may be engaged in the delivery of gender-affirming or reproductive health care.

Additionally, NYSAFP has been working directly with Senator Mayer in partnership with ACT to develop a bill to further protect medication abortion care by expanding current NYS law enabling providers to remove their name from a prescription label to give patients that same choice. As attacks on abortion access continue and even increase across the country, it's imperative that identifying information be omitted as much as possible.

We have also submitted testimony before the New York City Department of Health and Hygiene on NYSAFP's behalf regarding the proposed amendment to Article 203 of the New York City Health Code. This critical change will align the City Health Code with NYS Law and not only save clinicians time and reduce administrative burden as the information required to be reported for abortion care is significant (includes the names of the medical facility and clinician providing the care, demographic and residence information about the patient, etc.), but also further protect provider and patient confidentiality and safety.

Primary Care Recruitment and Training: The Academy has long supported legislation to establish a personal income tax credit for clinicians who provide preceptor instruction to students, S7701/A2230. The bill was passed by the Senate in 2024 and we will work to re-up this effort with bill sponsors and other supportive organizations ahead of the 2026 budget process. We have also worked to support increased funding for primary care recruitment and retention efforts and are happy to share that we successfully broadened the criteria for Doctors Across New York (DANY) for 2025 to allow limited liability partnerships (LLPs) and physicians working for LLPs to be eligible for a DANY award.

Insurance & Payment Reforms: We are continuing to advocate for a single payer system (S3425/A1466) and pursue greater investments in primary care by supporting legislation to require a minimum investment of the health care spend in the State for primary care (S1634/A1915-A). The Academy recently joined with a number of organizations on a sign-on letter to the Governor urging her to include this policy in her SFY 2026-27 Executive Budget. We also continue to advocate for insurance simplification and reforms to remove insurance barriers to access to care and time-consuming processes imposed on physician practices. We will continue these efforts in 2026.

Other Notable Actions: NYSAFP secured a meeting with the State Board of Medicine in October to discuss 2025 COD Resolution 25-03 and are happy to share that discussions went well regarding standardizing medical licensing requirements for international and domestic medical graduates. Following a lengthy discussion among State Board of Medicine members at their meeting in early December, regarding reducing the three-year experience requirement to one-year for the 17 international medical schools that have been approved for long-term clerkships, the Academy has sent another letter with information and data to support their ongoing deliberations. Additionally, NYSAFP requested a follow-up meeting to present an alternative idea to utilize objective ACGME milestone evaluations as a performance measure to determine who can get their unrestricted license during residency.

New York State Election Update

With a national spotlight on the highly contested New York City (NYC) mayoral race, Zohran Mamdani triumphed over former Governor Andrew Cuomo and Republican candidate Curtis Sliwa in November to become the first Muslim and South Asian mayor-elect, with a nearly nine percentage point lead against Cuomo. After formally entering the race in the fall of 2024, the 34-year-old State Assemblyman quickly rose into the public eye due to his bold democratic socialist agenda and focus on affordability and relating to everyday people. Given the looming impacts of federal cuts enacted earlier this year, only time will tell how Mamdani will address enormous economic and political pressures facing the city.

In the meantime, as he prepares to be inducted as mayor in January 2026, Mamdani's women-led team include former first deputy mayor Maria Torres-Springer, former Federal Trade Commission Chair Lina Khan, nonprofit president Grace Bonilla, and city budget expert Melanie Hartzog, who serve as his transition co-chairs. Further, progressive political strategist Elana Leopold, a de Blasio alum and senior Mamdani campaign adviser, will lead staff as Executive Director. Together, they have years of experience working in former mayoral administrations with backgrounds in social services, finance, city budgeting and housing development. To begin our conversations with his office and relationship-building, the Academy sent him a letter congratulating him on his victory and encouraging him to support universal healthcare coverage through a single payer health plan in New York State. Given it's consistent with his other priorities, his support would greatly enhance prospects of finally achieving universal healthcare coverage in New York.

Impact on the State Senate and Assembly

With Mamdani's win, three Democratic Socialists of America (DSA) members have indicated they are interested in running to represent Assembly District 26 in Queens. According to a *City & State* article, the candidates include Diana Moreno, who has been deeply involved in DSA and helped to elect DSA-endorsed candidates; Mary Jobaida, a past candidate for neighboring Assembly district 37; and Rana Abdelhamid, a

continued on page 8

continued from page 7

Muslim community organizer and founder of a women's self-defense organization. Additionally, as anticipated, changes are coming in Manhattan across multiple levels as current State Senator Brad Hoylman-Sigal (D) won the Manhattan borough president election and current State Assemblymember Harvey Epstein (D), representing the Lower East Side, was elected to the New York City Council District 2. Current Assemblymember Tony Simone has indicated that he may run for Hoylman-Sigal's seat and local City Council members may also be interested, while candidates for Epstein's seat remain unclear. Simone's decision to run and subsequent potential victory would also trigger another special election for the 75th Assembly District, covering Chelsea, Hell's Kitchen, Midtown, and part of the Lincoln Center area.

Taking a look upstate, as detailed below, current State Senator Sean Ryan's win has prompted a special election for the 61st Senate district with candidates including Erie County Democratic Party Chair Jeremy Zellner and current Assemblymember Jonathan Rivera who co-chaired Ryan's mayoral campaign. If Assemblyman Rivera wins, this would trigger a special election for the 149th Assembly District representing parts of the cities of Buffalo and Lackawanna, the town of Hamburg including the villages of Blasdell and Hamburg, and the hamlet of Lake View. Additionally, in the special election for State Assembly District 115 in the North Country to replace Democrat Billy Jones, Michael Cashman was declared the winner. Beating out Republican candidate Brent Davison, Cashman (D) served as the youngest town supervisor in Plattsburgh's history and was in office for nine years. Allegedly, Governor Hochul is considering February 3rd as the special election date for these vacant or soon to be vacant seats.

Mayoral Elections and Beyond

History was also made with voters electing Democrats Dorcey Applyrs and Sharon Owens as the first Black mayors of Albany and Syracuse. Malik Evans (D) was also reelected to serve a second term as mayor of Rochester, easily beating out the Republican challenger while noting however in his victory speech that he commends all candidates for running as "this is a tough time to be an elected official." Additionally, current State Senator Sean Ryan defeated Republican and Independent candidates in the mayor's race in Buffalo to become the city's first newly-elected mayor in 20 years.

Bills Passed by Both Houses in 2025, of Interest to NYSAFP

Prohibiting Prior Authorization for Certain HIV Medications (A26, Rosenthal/ S5534, Hoylman-Sigal)

This bill amends the public health law to prohibit Medicaid service providers from requiring prior authorization for antiretroviral prescription drugs for the treatment of prevention of HIV or AIDS. *Delivered to the Governor on December 8, 2025 with a deadline for her to act by December 19, 2025.*

Insurance Coverage for Inhalers (A128-A, Gonzalez-Rojas/ S1804-A, Rivera)

This legislation amends the insurance law to require insurance coverage for one rescue and one maintenance inhaler and would not be subject to a deductible, copayment, coinsurance, or any other cost-sharing requirement. *This legislation was signed into law on 11/21/25, chapter 504 of the laws of 2025 and takes effect on January 1, 2027.*

Medical Aid in Dying (MAID) Act (A136, Paulin/ S138, Hoylman-Sigal)

This bill amends the public health law to allow a terminally ill, mentally capable adult with a prognosis of six months or less to live to request for a prescription for medication that they can take to bring about a peaceful death at a time of their choosing, should they decide to use it. *To be signed in January 2026 contingent on State Legislature Passing Amendments.*

Hospital Violence Prevention Program (A203-B, Cruz/ S5294-B, Sepulveda)

This legislation amends the public health law to require hospitals to establish a violence prevention protection program including the establishment of security personnel in hospital emergency departments to protect from violence and verbal and physical abuse of doctors, nurses and staff who provide critical medical care in such emergency departments. *This bill was signed into law on 12/12/25, chapter 618 of the laws of 2025 and takes effect on September 18, 2026.*

Intrauterine Device Informational Pamphlet (A778-A, Rosenthal/ S7714-A, Gonzalez)

This bill amends the public health law to direct the Department of Health (DOH) to create an informational pamphlet concerning intrauterine devices which would be required to be available on the department of health's website. It would also require practitioners to distribute the informational pamphlet to patients seeking contraceptives. *This legislation was vetoed and tabled on 10/17/2025 and we sent the Governor a letter prior to this action explaining our concerns with the legislation, as well as A2168/S7545 mentioned below, urging her to veto them to protect the patient-provider relationship and prevent efforts to mandate specific information when counseling patients.*

Patient Drug Use Reporting (A1894, Paulin/ S3362, Rivera)

This legislation repeals section 3372 of the public health law to remove the requirement that an attending or consulting practitioner report to the DOH Commissioner a person's name, address, and other data as required, if a person under treatment is found to be an addict or a habitual user of any narcotic drug. *This bill was signed into law on 10/16/25, chapter 442 of the laws of 2025 and took effect immediately.*

Episiotomy Information (A2168, Paulin/ S7545, Brouk)

This bill amends the public health law to require DOH to develop and maternal health care providers to distribute written information about the risks associated with episiotomies to maternity patients. *This legislation was vetoed and tabled on 10/17/2025.*

Still Birth or Pregnancy Loss Certificate Fee (A2311-A, Zaccaro/ S1807-A, Fernandez)

This bill amends the public health law to prohibit charging a fee for the issuance of a certificate of still birth or pregnancy loss. *This bill*

continued on page 9

continued from page 8

was signed into law on 11/21/25, chapter 510 of the laws of 2025 and took effect immediately.

Reproductive Health Services Education and Outreach Program (A2581-A, Gonzalez-Rojas/ S3285-B, Gonzalez)
This legislation amends the public health law to create a DOH Education and Outreach Program on Reproductive Health Services for consumers, patients, educators, and health care providers related to reproductive health services available in New York State including, but not limited to: access to family planning services such as contraceptives and pregnancy testing, testing and treatment for sexually transmitted infections, and any other health conditions or information the DOH Commissioner deems necessary. Other information required to be provided includes counseling, telehealth services, and financial assistance available through state agencies, complications from pregnancy that can endanger the life or health of the newborn or mother, and the symptoms risks, transmission, and prevention of cytomegalovirus and the effects of such virus. *This legislation was vetoed and tabled on 10/17/2025.*

Out-of-State Licensed Athletic Trainers (A2643-A, Solages/ S5275-A, Bailey)
This bill amends the education law to permit certain licensed athletic trainers who are licensed to practice in another state, territory, or country to provide athletic training services to athletes and team personnel at a discrete sanctioned team sporting event or performance in New York State. *This bill was signed into law on 11/21/25, chapter 512 of the laws of 2025 and took effect immediately.*

Transvaginal Ultrasounds (A3280-A, Bichotte Hermelyn/ S3323-A, Scarcella-Spanton)
This legislation amends the insurance law to require insurance policies to provide coverage for transvaginal ultrasounds during pregnancy. *This legislation was signed into law on 10/16/25, chapter 447 of the laws of 2025 and takes effect on 1/1/27.*

Use of Virtual Credit Cards by Insurers and Certain Health Care Plans (A3986-A, Bores/ S2105-A, Cooney)
This bill amends the insurance and public health laws to allow the use of alternative payment methods for claims including credit card, virtual credit card, or electronic funds transfer that imposes on the provider a fee or similar charge to process the payment. The insurer would be required to first notify the patient provider of the potential fees or charges, offer the provider an alternative payment method that does not impose fees or charges, and allow the provider or a designee to elect to accept such payment type. It also establishes that an election to accept or not accept a specific type of payment shall remain in effect until it is changed and requires an insurance carrier to seek permission to charge a fee solely to transmit a payment to a provider. *Delivered to the Governor on December 8, 2025 with a deadline for her to act by December 19, 2025.*

Cost Sharing Requirements (A5367-A, Weprin/ S6895-A, Bailey)
This bill amends the insurance law to clarify that with respect to the application of any cost-sharing requirements adopted by the state for health insurance plans, policies, and coverages, if the application of those requirements would prevent Health Savings Account (HSA)-qualified plans from meeting the requirements under federal law (26 USC 223), the relevant requirement would only apply to HSA-qualified plans after the federal required minimum deductible has been met. However, this exception would not apply to items or services considered "preventive care" by the IRS under federal law. The purpose of this legislation is to ensure that consumers, insureds/enrollees, and HSA owners can continue to fund their HSAs to pay for qualified medical expenses on a tax-advantaged basis. *This bill was signed into law on 12/12/25, chapter 625 of the laws of 2025 and took effect immediately.*

Medical Malpractice Insurers (A6595, Weprin/ S7221, Bailey)
This legislation amends the insurance law to extend the risk-based capital requirements of Insurance Law 1324 for those stock and non-stock insurers to which 1324(b)(2)(B) applies until 12/31/28. It would also extend the prohibition on making an application for an order or rehabilitation or liquidation of a domestic insurer. *This legislation was signed into law on 8/7/25, chapter 222 of the laws of 2025 and took effect immediately.*

Amyotrophic Lateral Sclerosis (ALS) and Motor Neuron Disease (MND) Registry (A7845, Stern/ S6413, Scarcella-Spanton)
This bill amends the public health law to require DOH to establish a registry for the collection of information on the incidence and prevalence of ALS and MND in the state. Every physician, nurse practitioner, physician assistant and general hospital that diagnoses or treats a patient diagnosed with ALS or MND would be required to give notice to the department of cases of ALS or MND coming under their care and requires that patients diagnosed with ALS or MND be provided with written and verbal notice regarding the collection of information and patient data on ALS and MND. It also provides patients with the right to opt-out of the collection of data. *This bill was signed into law on 10/17/25, chapter 478 of the laws of 2025 and takes effect on January 15, 2026.*

Expansion of Several Home Care Services (A7907, Seawright/ S7077, Cleare)
This legislation amends the elder law to modify the Expanded In-Home Services for the Elderly Program (EISEP) to eliminate the cost share requirement for EISEP services and to eliminate any requirement for the Area Agencies on Aging (AAAs) to obtain a physician's order to provide non-medical support under EISEP funding. *This legislation was vetoed and tabled on 12/12/2025.*

Assessment-Based Treatment Plans (A8045, Bronson/ S7622, Brouk)
This bill amends the education law to authorize licensed mental health counselors, marriage and family therapists, and psychoanalysts to engage in diagnosis and the development of assessment-based treatment plans. It would also allow these mental health practitioners currently working in certain settings, as defined by SED in regulations, provided that such settings shall not include a private practice owned or operated by the applicant, to continue to diagnose through June 24, 2027. *This bill was signed into law on 6/18/25, chapter 140 of the laws of 2025 and took effect immediately.*

continued on page 10

continued from page 9

Health Information Protection
(S929, Krueger/ A2141, Rosenthal)
This bill amends the general business law to create a legal framework for New Yorkers to reclaim and retain control of their healthcare information by requiring electronic apps or websites that provide a diagnosis or retain health information to receive affirmative consent by the user to retain such information. Electronic apps or websites would also be required to provide users the ability to rescind such consent. *Delivered to the Governor on December 8, 2025 with a deadline for her to act by December 19, 2025.*

General Hospital Closure Notice
(S1226, Rivera/ A6004, Simon)
This legislation amends the public health law to require public notice and public engagement when a general hospital seeks to either close entirely or close a unit that provides emergency, maternity, mental health, or substance use care no later than 270 days before the proposed closure date and requires hospitals to confer with DOH prior to giving written notice. DOH would then be required to hold a public community forum to obtain public input no later than 30 days after to 150 days before the proposed closure and revised unit closure plans addressing community concerns must be submitted by the hospitals within 30 days after the forum. *Delivered to the Governor on December 8, 2025 with a deadline for her to act by December 19, 2025.*

Tick-Borne Illnesses Report
(S1786, Hinchey/ A6047, Schiavoni)
This bill amends the public health law to require DOH to develop annual reports on tick-borne illnesses which must be available on their website and requires the superintendent of the Department of Financial Services to review the status of health insurance coverage for the treatment of Lyme disease and other tick-borne related diseases. *This legislation was vetoed and tabled on 12/5/2025.*

Medical Use of Cannabis
(S3294-A, Cooney/ A4759-A, Peoples-Stokes)
This legislation amends the cannabis law to update the medical cannabis program to remove the requirement that medical cannabis practitioners consult the prescription monitoring system, provide the cannabis control board authority to allow practitioners to provide patients with a QR code, or similar tool, to obtain medical cannabis, provide that certifications are valid for two years, allow practitioners to extend certain certification expirations, and provide that practitioners must complete appropriate training as determined by the board in regulation. It would also replace registry identification cards with a system for validating medical cannabis certifications and provide medical cannabis reciprocity with other states, territories, and the District of Columbia. *This bill was signed into law on 11/21/25, chapter 544 of the laws of 2025 with certain sections taking effect immediately and others taking effect 90-180 days after enactment.*

Digital Health Service Platforms
(S3355-A, Rivera/ A4179-A, Stirpe)
This bill amends the public health law to clarify the existing law to reflect that healthcare technology platforms do not provide temporary employment services directly, instead providing digital health care service platforms, and clarify that these are intended to be covered under the law. *This bill was signed into law on 12/5/25, chapter 598 of the laws of 2025 and took effect immediately.*

Hospital Rule-Based Exclusions
(S3486, Hinchey/ A3862, Rozic)
This legislation amends the public health and insurance laws to require DOH to collect a list of hospital rule-based exclusions from each hospital and publish the list of general hospitals that have these exclusions and specifically what they are on DOH's website to provide patients and the public with information prior to admission to a hospital. *Delivered to the Governor on December 8, 2025 with a deadline for her to act by December 19, 2025.*

Wrongful Death
(S4423, Hoylman-Sigal/ A6063, Lunsford)
This bill amends the estates, powers and trusts law to authorize an award in a wrongful death action to include compensation for grief or anguish, the loss of services and support, and the loss of nurture and guidance and would allow a claim to be filed up to three years after the decedents' death. *This legislation was vetoed and tabled on 12/5/2025.*

Reproductive and Gender-Affirming Care Protections
(S4914-B, Hoylman-Sigal/ A5480-C)
This legislation amends several areas of law to prevent the state from engaging with hostile actors attempting to restrict access to reproductive health care and gender-affirming care. It would also build on professional discipline and medical malpractice protections in New York's shield laws by extending these to more providers that may be engaged in the delivery of gender-affirming or reproductive health care. NYSAFP sent an individual letter and joined with a number of organizations on a sign-on letter to the Governor urging her to sign this bill into law as soon as possible. *It was delivered to the Governor on December 8, 2025 with a deadline for her to act by December 19, 2025.*

Epinephrine Device Definition
(S7807-A, Gounardes/ A5392-B, Rosenthal)
This bill amends the public health law to expand the definition of epinephrine devices beyond auto-injectors devices to include epinephrine nasal sprays. *We sent a letter to Governor Hochul and the Commissioner of DOH in August urging her to sign this legislation as soon as possible given schools are now required to have epinephrine available on-site. It was signed into law on 11/12/25 and took effect immediately.*

All of us at Reid, McNally & Savage would like to thank the Leaders and full membership of NYSAFP for your strong support and advocacy this year. We look forward to continuing to work with you in 2026 to pursue priorities of importance to family physicians and your patients.

SUPPORT NYS ASSEMBLY BILL 1915-A: THE “PRIMARY CARE INVESTMENT ACT”

New York State
Academy of
Family Physicians

WHY SUPPORT THIS BILL?

Investing in primary care is associated with better outcomes at lower cost, and decreases health disparities. Our current health care system is financially unsustainable and does not adequately address patients’ health needs nor health disparities. This bill is intended to shift investment to improve access to high quality primary care while containing total healthcare costs.

What it does: Increases proportion of dollars spent on primary care in NYS.

- Requires payors (insurance plans and Medicaid) to increase the percentage of spend devoted to primary care* to at least 12.5% starting in 2027 by at least 1% per year until target is reached.
- May do this by direct payment for primary care services, or by paying to improve delivery of primary care.
- Payors instructed to shift current spending without increasing total medical expenditures or increasing premiums or cost-sharing
- Requires annual reporting of percentage of spending devoted to primary care starting in 2026 by payors.

***primary care** = integrated, accessible health care provided by primary care clinicians** responsible for addressing most of a patient’s health care needs.*

***** primary care clinicians** = physicians and APCs in family medicine, general pediatrics, primary care internal medicine, primary care OB/GYN, and behavioral health when integrated into a primary care setting.*

How Can You Help?

The corresponding Senate Bill 1634 has already passed the NYS Senate.

**Please support Bill 1915-A by writing to your representative in the Assembly.

TWO VIEWS:
The Press Ganey

VIEW ONE

DISTORTED METRICS WITH DISTORTED OPTICS

By Ani A. Bodoutchian, MD, MBA, FAAFP and Mary A. Chirinian, MBA

Patient satisfaction has become a dominant measure in modern healthcare. Press Ganey surveys are the most widely implemented tool to assess patient perceptions of the quality of care provided.[1]

While the intent is to elevate patient voices by capturing elements of patient experience such as communication, wait times, provider empathy and encouraging patient-centered care, the widespread reliance on Press Ganey scores does have significant limitations which may be swept under the rug.

For family physicians, who often serve as the entry point into the healthcare system and manage a wide range of physical, mental, and social health concerns, the limitations of Press Ganey carry particular importance.

POOR CORRELATION WITH QUALITY

A central critique of Press Ganey is its poor linear correlation with objective quality metrics.[2] Family medicine emphasizes continuity and preventive health, which do not always yield immediate gratification for patients. For example, necessary encouragement of lifestyle changes for obesity, or counseling against unwarranted opioid prescriptions may face resistance and result in Press Ganey scores that are truly not reflective of the rendered care. Another example is that a physician who appropriately refuses unnecessary antibiotics may receive lower satisfaction scores despite delivering higher quality care. Thus, overreliance on these surveys, risks rewarding short term satisfaction over long term health outcomes.

For family physicians, whose clinical effectiveness is often tied to long term outcomes, such as controlling chronic diseases and promoting preventive screenings, this disconnect is problematic. There is a clear discrepancy between how family doctors create value and how healthcare systems typically measure and reward performance. This incongruity devalues the core work of family physicians and makes medicine seem one size fits all.[3,4,5] High patient satisfaction may reflect friendliness or convenience rather than adherence to quality and appropriate medical care.[3,4,5]

INFLUENCE OF NON-CLINICAL FACTORS

Press Ganey results are heavily influenced by factors outside the physician's control. Wait times, front desk staff demeanor, nurse or assistant, parking availability or whether the patient received a desired prescription often matter more than clinical quality.[1,7] For family physicians, who often have busy practices with limited staffing, such extraneous factors can unfortunately disproportionately impact scores.

continued on page 13

VIEW TWO

ENHANCING PATIENT SATISFACTION THROUGH STRUCTURED COMMUNICATION AND CONTINUITY OF CARE INTERVENTIONS IN INPATIENT FAMILY MEDICINE

By Alexis Castro; Crystal Mehdizadeh; Aurelio Diaz; George V. Alvarez, MD and Donna Montesano, RN

INTRODUCTION

Patient experience is central in medicine, holding equal importance to clinical outcomes both in and out of the hospital. Many health systems utilize Press Ganey surveys as a standardized measure of patient feedback regarding factors such as communication, hospital environment and comfort, care transitions, and discharge planning.

Family medicine physicians have a profound impact on patient satisfaction scores by virtue of their role as the primary communicators and leaders of care. Patients often judge the quality of their care by how well the hospitalist explains their diagnosis, treatment options, and discharge instructions, and how effectively these explanations address their concerns. Additionally, because illness often brings fear and uncertainty, providing regular updates to a patient's loved ones helps address the psychosocial needs of families. Previous physician coaching interventions that have improved satisfaction scores focused on areas such as keeping patients informed and using understandable language.[1]

Strong communication combined with close follow-up is key to patient satisfaction with their family medicine physicians, as it shapes the patient's perception of care quality. At NYU Long Island Hospital, the Family Medicine Service recognized these core aspects and sought to create a framework that optimizes the approach to communication, family updates, and discharge follow-up.

METHODS

Following a decrease in Press Ganey scores in the fourth quarter of 2024 (October 1st to December 31st), the Family Medicine Service conducted a multifaceted review of factors that impact patient satisfaction. This review included revisiting provider communication scripting, physician-led appreciative coaching, best practices for discharge instructions, and family update workflow. The updated methods were implemented in the first quarter of 2025 (January 1st to March 31st). Following this initiative, patient satisfaction scores, tracked using Press Ganey surveys, showed a noticeable improvement compared to earlier quarters.

Structured Patient Communication & Appreciative Coaching

Improving patient experience begins with communication. NYU adopted the established AIDETT framework — Acknowledge, Introduce, Duration, Explanation, Teach Back, and Thank — to foster clarity, understanding, and trust between providers and their patients. A June 2020 study exploring the application of the AIDETT model on patients anticipating cataract operations

continued on page 15

continued from page 12

Additionally, family medicine often involves managing complex psychosocial issues, mental health, substance use, and chronic pain which may not be immediately resolved. Since satisfaction is tied more to the patient's perception of the care experience, such disappointments with outcomes, even when inevitable, may translate into lower satisfaction ratings.[8]

PROFESSIONAL MORALE/BURNOUT

Perhaps most concerning is the impact of Press Ganey surveys on physician mental well-being. Family physicians already face high rates of burnout due to heavy patient loads, administrative burdens, and emotional stress. When satisfaction scores are tied to compensation or public reporting, physicians may feel pressured to prioritize satisfaction over medical judgment.[6] For family physicians, who frequently face patient requests for unnecessary medications, imaging or referrals, the ethical tension is very real. Prioritizing scores over best practices undermines both professional integrity and patient safety.

Press Ganey surveys often provide delayed, aggregated comments, leaving physicians unable to address issues in real time.[9] When employees receive harsh or unjust feedback from corporate leadership, it erodes their trust, damages their confidence, lowers morale, and can ultimately harm the practice itself.[9]

CEILING EFFECTS

Press Ganey surveys also suffer from high ceiling effects. This survey uses a 5-point Likert scale and does not have enough range to distinguish between the highest levels of performance or satisfaction. This causes scores to cluster at the top of the scale.[10] What does this mean for family doctors? Statistical clustering reduces the discriminatory value of the surveys.[11]

A small numerical difference may translate into a large percentile rank shift, making one physician appear dramatically better or worse than another based on trivial variation. This volatility undermines fairness.[9] Two family physicians delivering identical care could be ranked very differently depending on small differences in patient perceptions, wait times or the survey sample. When these rankings influence compensation, bonuses or public reputations, family physicians may feel that their careers are at the mercy of chance rather than performance.[6]

BIAS

Nonresponse bias—the systematic error introduced when individuals refuse, are unable, or are unreachable to participate—represents a significant limitation in survey-based data collection.[3] This bias is particularly salient in family medicine, where physicians often serve socioeconomically diverse populations from deprived backgrounds. Their practices may be underrepresented in survey results or receive systematically lower satisfaction ratings, independent of the actual quality of care provided.[3,4]

Physicians practicing in underserved areas may therefore face disproportionate penalties, as their patients are both less likely to complete surveys and more likely to experience social stressors that influence responses beyond clinical quality.[3,4,5] As healthcare systems increasingly link physician compensation and reputation to patient experience metrics, such as those derived from Press Ganey surveys, these structural inequities risk amplifying existing disparities.[3,4,5] For family medicine—whose foundational mission is to deliver equitable care regardless of background—this form of bias is particularly concerning.

The effects of nonresponse bias are compounded by the demographic characteristics of typical survey respondents. Patients who complete Press Ganey surveys are disproportionately White, English-speaking, older, more educated, and privately insured, leading to the systematic underrepresentation of underserved populations, including Spanish-speaking patients and those lacking reliable digital access.[14,15,16]

Empirical research supports these disparities. Non–English-speaking patients without consistent access to cell phones or the internet are frequently excluded from satisfaction data. Persistent language barriers contribute to lower scores on communication-related measures, and even when responses are submitted, these patients are less likely to provide qualitative feedback.[17]

A pronounced digital divide further exacerbates underrepresentation. Marginalized populations—particularly Hispanic and non–English-speaking individuals—tend to exhibit lower digital literacy and reduced access to technology, making electronically administered surveys via email or text disproportionately inaccessible.[16,18,19]

Finally, survey methodology itself perpetuates exclusion. Although offering surveys in Spanish is both common and essential, the method of distribution often remains a barrier. Traditional mail and telephone surveys yield low response rates among low-income and minority populations, while technology-dependent modes of administration may inadvertently disadvantage those already underserved.[18,19]

CONCLUSION AND REAL TIME IMPLICATIONS FOR FAMILY MEDICINE

Since 2001's Medicare's landmark publication *"Crossing the Quality Chasm,"* patient-centered care has become a priority, yet its use as a measurable quality indicator remains elusive.[6]

Press Ganey surveys offer insights but have significant limitations that make them problematic for evaluating physician performance with unclear implications for clinical practice.[6] The growing influence of Press Ganey surveys risks distorting family medicine practice and pushing physicians to prioritize satisfaction over clinical judgment. Underserved populations are systematically less likely to complete these surveys, which means their experiences and potential issues with care access or quality may be underrepresented in the final results.[14] Consequently, family physicians' risk being judged by these flawed patient satisfaction metrics, which are increasingly relied upon by health systems, insurers, and regulators.[6]

continued on page 14

continued from page 13

As we look to the future, there is a workforce shortage in primary care. Younger physicians may be deterred from family medicine if they perceive this specialty as unfairly evaluated and possibly further exacerbating the problem.[12] Recognizing the limitations of Press Ganey Surveys is essential to protect physician integrity, ensure fair evaluation, and maintain focus on the true goals of family medicine. Accordingly, healthcare systems should adopt a balanced and fair approach that values patient experience while safeguarding professional integrity, equity, and physician well-being.[13]

Endnotes

1. Stephens, A. R., Presson, A. P., Chen, D., Tyser, A. R., & Kazmers, N. H. (2021). Inter-specialty variation of the Press Ganey Outpatient Medical Practice Survey. Medicine, 100(12), e25211. https://doi.org/10.1097/MD.0000000000025211
2. Escobedo Y, Reed S, Payne S, Liu J, Navar M, Widmer RJ. An analysis of physician reviews in relation to quality and social media presence. Proc (Bayl Univ Med Cent). 2022 Jul 13;35(6):794-797. doi: 10.1080/08998280.2022.2090888. PMID: 36304604; PMCID: PMC9586681.
3. Stephens, A.R., Potter, J.W., Tyser, A.R. et al. Evaluating the impact of social deprivation on Press Ganey® Outpatient Medical Practice Survey Scores. Health Qual Life Outcomes 19, 167 (2021). https://doi.org/10.1186/s12955-020-01639-y
4. DeLoughery EP. Physician race and specialty influence Press Ganey survey results. Neth J Med. 2019 Dec;77(10):366-369. PMID: 31880269.
5. Tyser, A.R., Abtahi, A.M., McFadden, M. et al. Evidence of non-response bias in the Press-Ganey patient satisfaction survey. BMC Health Serv Res 16, 350 (2016). https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1595-z
6. Schneider BJ, Ehsanian R, Schmidt A, Huynh L, Kennedy DJ, Maher DP, Haring S. The effect of patient satisfaction scores on physician job satisfaction and burnout. Future Sci OA. 2020 Nov 12;7(1):FSO657. doi: 10.2144/fsoa-2020-0136. PMID: 33437508; PMCID: PMC7787140.
7. Rane, A. A., Tyser, A. R., Presson, A. P., et al. (2019). Patient satisfaction in the hand surgery clinic: An analysis of factors that impact the Press Ganey survey. Journal of Hand Surgery, 44(7), 539–547.e1. https://pmc.ncbi.nlm.nih.gov/articles/PMC6637964
8. Ferreira DC, Vieira I, Pedro MI, Caldas P, Varela M. Patient Satisfaction with Healthcare Services and the Techniques Used for its Assessment: A Systematic Literature Review and a Bibliometric Analysis. Healthcare (Basel). 2023 Feb 21;11(5):639. doi: 10.3390/healthcare11050639. PMID: 36900644; PMCID: PMC10001171.
9. Willner K. Real-time Patient Experience Surveys Lead to Better Scores. West J Emerg Med. 2025 Jun 25;26(4):810-814. doi: 10.5811/westjem.18713. PMID: 40795002; PMCID: PMC12342542.
10. Presson, A. P., Zhang, C., Abtahi, A. M., Kean, J., Hung, M., & Tyser, A. R. (2017). Psychometric properties of the Press Ganey® Outpatient Medical Practice Survey. Health and Quality of Life Outcomes, 15, 32. https://pmc.ncbi.nlm.nih.gov/articles/PMC5301343
11. Dalmaijer, E.S., Nord, C.L. & Astle, D.E. Statistical power for cluster analysis. BMC Bioinformatics 23, 205 (2022). https://doi.org/10.1186/s12859-022-04675-1
12. HRSA: Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report- 2024.pdf
13. West CP. Physician Well-Being: Expanding the Triple Aim. J Gen Intern Med. 2016 May;31(5):458-9. doi: 10.1007/s11606-016-3641-2. PMID: 26921157; PMCID: PMC4835383.
14. Roberts BW, Yao J, Trzeciak CJ, Bezich LS, Mazzarelli A, Trzeciak S. Income Disparities and Nonresponse Bias in Surveys of Patient Experience. J Gen Intern Med. 2020 Jul;35(7):2217-2218. doi: 10.1007/s11606-020-05677-6. Epub 2020 Jan 31. PMID: 32006345; PMCID: PMC7351907.
15. Patel A, Markatia Z, Sridhar J, Cavuoto KM. Effect of patient demographics and COVID-19 on Press Ganey scores in an ophthalmic emergency department. Am J Emerg Med. 2021 Dec;50:806-807. doi: 10.1016/j.ajem.2021.03.037. Epub 2021 Mar 17. PMID: 33757672; PMCID: PMC9758952.
16. Philpot LM, Ramar P, Roellinger DL, McIntee MA, Ebbert JO. Digital health literacy and use of patient portals among Spanish-preferred patients in the United States: a cross-sectional assessment. Front Public Health. 2024 Dec 10;12:1455395. doi: 10.3389/fpubh.2024.1455395. PMID: 39720810; PMCID: PMC11666482.
17. Gotschall JW, Fitzsimmons R, Shin DB, Takeshita J. Race, Ethnicity, and Other Patient and Clinical Encounter Characteristics Associated with Patient Experiences of Access to Care. J Patient Exp. 2024 Mar 24;11:23743735241241178. doi: 10.1177/23743735241241178. PMID: 38529206; PMCID: PMC10962025.
18. Alkureishi MA, Choo ZY, Rahman A, Ho K, Benning-Shorb J, Lenti G, Velázquez Sánchez I, Zhu M, Shah SD, Lee WW. Digitally Disconnected: Qualitative Study of Patient Perspectives on the Digital Divide and Potential Solutions. JMIR Hum Factors. 2021 Dec 15;8(4):e33364. doi: 10.2196/33364. PMID: 34705664; PMCID: PMC8675564.
19. Harrison R, Iqbal MP, Chitkara U, Adams C, Chauhan A, Mitchell R, Manias E, Alston M, Hadley AM. Approaches for enhancing patient-reported experience measurement with ethnically diverse communities: a rapid evidence synthesis. Int J Equity Health. 2024 Feb 12;23(1):26. doi: 10.1186/s12939-024-02107-5. PMID: 38342909; PMCID: PMC10860321.

__Ani Bodoutchian MD, MBA, FAAFP, DABOM, CPE__ is dual board certified in family medicine and obesity medicine. She graduated from the Universidad Autonoma de Guadalajara School of Medicine in Mexico and completed her residency at South Shore University Hospital, Northwell Health. Dr. Bodoutchian has been involved in teaching medical students, residents, fellows, and nurse practitioner students for over two decades. She is currently Clinical Associate Professor at Stony Brook Medicine, Associate Professor of Family Medicine Stony Brook School of Nursing, Clinical Associate Professor of Family Medicine at Zucker Hofstra /Northwell School of Medicine and Associate Professor of Family Medicine and General Practice at St. George's University School of Medicine.

__Mary Chirinian, MBA__, is Practice Administrator at Stony Brook Medicine. She is a highly experienced healthcare administrative professional with nearly three decades of expertise in practice administration and healthcare management, specializing in streamlining operations within complex medical environments, and managing complex healthcare operations and personnel. Mary earned her bachelor's degree in business administration from St. John's University and her master's degree in human resource management from Walden University.

continued from page 12

concluded a reduction in anxiety and improvement of satisfaction to care services.[2] NYU sought to expand its utility with AIDETTWF — "What Else?" and "Family Update."

The AIDETT framework is an acronym that provides a structured approach to physician-patient interactions in both the inpatient unit and outpatient clinic. "Acknowledge" prompts physicians to greet patients and others in the room professionally. "Introduce" encourages providers to state their name, title, and role, which is especially valuable when multiple teams participate in the patient's care. "Duration" includes establishing expectations for a procedure, test, or care process times. "Explanation" focuses on delivering clear information about the patient's care plan and future steps. "Teach Back" allows the patient to verbalize their understanding directly to the physician for potential clarification, and "Thank" closes the encounter with respect and appreciation. Regarded as one of the most widely adopted models, AIDETTWF adds two components. "What Else" seeks to ask an open-ended question and ensure all the patient's concerns have been addressed. "Family Update" not only establishes who to contact but confirms which updates should be shared to uphold patient autonomy.

This approach to communication ensures that each interaction is intentional and transparent, addressing patient concerns while clearly setting expectations. AIDETTWF not only establishes rapport between physicians and patients but helps patients feel more empowered and assured about their treatment.

In addition to the benefit to patients, appreciative coaching was also incorporated into provider-patient interactions utilizing AIDETTWF. The purpose of a care team learner and coach for observation is to oversee the interaction and provide constructive feedback that is conducive to positive change. Prior to the encounter, the coach will lay the groundwork for the model and share positive intent. In debrief, the coach will reinforce the expected behaviors based on the learner's self-assessment. This approach was implemented in sessions, initially introduced during medicine unit rounds, phased in with shadowing as care members underwent appreciative coaching with colleagues, and finally incorporating advanced practice provider leaders and chiefs.

Figure 1: The NYU "famupdate" smart phrase for daily family updates

@TODAYDATE@

TIME: @NOW@

Family/Caregiver called by: @ME@

Method of Contact: {Method of Contact:30881002}

Was family/caregiver reached: {yes no:327201}

Family Updates

The family contact identified through AIDETTWF is documented in the electronic health record at the patient's first encounter during an admission by any member of the care team. Upon daily inquiry, the team member will look at the prior day's note to see who the family update should be given to. They will re-inquire with the patient about the extent of information and if the contact is still appropriate. Family updates can be either in-person or by phone. Using the electronic health record's smart phrase feature, a template for family updates will be generated. The smart phrase "famupdate" will create a template including: the provider's name, method of contact, and whether the family or caregiver was reached (Figure 1). The expectation is that one family update is completed daily. However, if there are changes in the plan of care throughout the day, another family update will be provided.

Discharge Follow-Up

The Family Medicine Service at NYU Long Island Hospital reshaped its discharge process with proactive measures designed to enhance recovery and satisfaction. First, there was a focus on discharge information; all information regarding a patient's visit and medications were provided (e.g., signs and symptoms). This, along with incorporating teach-back and open-ended dialogue during each encounter, reinforced confidence and satisfaction.

When a patient is discharged, nurses follow them closely during the transitional care window. Patients are contacted within two business days of discharge to evaluate their status and ensure they are adhering to prescribed recommendations.

Through the electronic medical record smart phrase feature "CPTCM", a template for a transition care management note is generated. Each patient is scheduled for follow-up appointments within 7–14 days (Figure 2). If they are unable to attend an in-person visit, video consultations are arranged, though in-person evaluations remain the gold standard where feasible.

This individual-focused follow-up program addresses the risk of complications and reinforces continuity of care, offering patients a safety net during their vulnerable recovery periods. It significantly reduces stress for patients who might otherwise feel isolated upon leaving the hospital.

DISCUSSION

Each strategy utilized by the Family Medicine Service at NYU Long Island Hospital aims to address a specific component of the patient's journey in order to create a cohesive model that promotes clarity, rapport, and continuity.

The implementation of AIDETTWF into clinical practice has proven especially impactful. By standardizing how physicians communicate expectations, explain

continued on page 16

Figure 2: The NYU "CPTCM" smart phrase for patient discharge and follow up

Post discharge follow up - Transition care management

Patient gets Discharged

Next day New note written and: .CPTCM

Hospital discharge follow up call and appointment required (provided to nurses who schedule):

@NAME@ is a @AGE@ @SEX@ was discharged on @MRDDISD@ from the hospital.

Please contact patient within the next two business days to evaluate their clinical status.

Please ensure they schedule an appointment with our office to be seen ideally within the next **7 days** if possible, if not within the next 14 days from their date of discharge.

If the patient already has an appointment within the next 14 days please contact them to confirm the appointment and follow-up on their post hospitalization status.

If the patient is unable to come into the office a video visit can be done however in person evaluation is preferable.

@MEMO@

continued from page 15

care plans, verify understanding, and close each interaction, the framework ensured that patients consistently received clear and comprehensible information concerning their hospitalization. NYU's expansion with "What Else?" and "Family Update," filled two common care gaps in communication: unanswered patient concerns and uncertainty among families regarding the plan of care. The cumulative application of this framework allowed patients to feel heard and supported in a time of uncertainty. Appreciative coaching further reinforced these behaviors by providing physicians with constructive feedback in real-time, strengthening communication habits, and ensuring model fidelity. Physician communication is significantly positively correlated with patient adherence; there is a 19% higher risk of non-adherence among patients whose physician communicates poorly than among patients whose physician communicates well.[4]

In a 2014 systematic review, lack of communication was identified as the most common category of concerns raised by patients in inpatient care settings.[5] Daily family updates directly addressed this by creating a protocol in which updates are delivered. By documenting the preferred family contact and expectations in electronic health records, the team established a transparent and dependable system for patient-family engagement. Families consistently received timely updates, and disruptions in communication were minimized. This reliability not only enhanced trust but also ensured that families remained aligned with the care plan, reducing miscommunication and uncertainty.

Similarly, the structured discharge follow-up process addressed the transitional period after hospitalization. Referred to as the "vulnerable period," this is defined by high rates of medication errors and limited patient understanding. The abrupt drop-off in physician oversight further leaves patients feeling unsupported and lost. Early nursing calls and timely outpatient appointments provided patients with reassurance, clarified instructions, and enabled early identification of complications or unmet needs. Coupling these calls with the teach back method helped identify misunderstandings before it could lead to non-adherence or decline in health. Close follow-up has been well established with decreased readmission rates and lower healthcare costs.[6] Per a 2024 literature review, there is no significant difference in patient satisfaction between inpatient or telemedicine follow-up, although in-person remains the golden standard.[3] By maintaining continuity and demonstrating ongoing support, the service reinforced patient confidence and strengthened the perceived quality of care.

Collectively, these initiatives contributed to a marked improvement in Press Ganey scores in the quarter following their implementation. The rise in patient satisfaction reflected not only a positive response to the individual components but also the synergistic effect of an integrated, patient-centered approach. As demonstrated in previous literature, clear communication and coordinated follow-up do more than shape patient perceptions; they directly enhance safety and outcomes.

Overall, the Family Medicine Service's experience shows that intentional communication, consistent family engagement, and thoughtful transition planning are powerful levers for strengthening the patient experience. When systematically implemented and reinforced through coaching and documentation, these strategies not only elevate satisfaction metrics but also deepen trust and improve the quality of care delivered across the continuum. Outside of academic settings like NYU, such strategies can be tailored to different hospitals and practices. In small community hospitals, one might focus on consistent communication patterns and prioritize post-discharge calls using available nursing teams. Alternatively, larger urban facilities could scale up efforts by leveraging existing resources for telehealth and digital follow-up systems, ensuring contact for discharged patients in a manner suitable for local needs.

CONCLUSION

The integration of structured communication, routine family engagement, and coordinated discharge follow-up enhanced patient satisfaction within the Family Medicine Service at NYU Long Island Hospital. These interventions improved Press Ganey survey scores, demonstrating that patient-centered communication is a powerful driver of both subjective perception and outcomes. Sustaining these practices and expanding them where appropriate will continue to strengthen the continuity, safety, and quality of care across the inpatient-outpatient transition.

Endnotes

1. Seiler, A., A. Knee, R. Shaaban, C. Bryson, J. Paadam, R. Harvey, S. Igarashi, C. LaChance, E. Benjamin, and T. Lagu. "Physician Communication Coaching Effects on Patient Experience." PLoS One 12, no. 7 (2017): e0180294. https://doi.org/10.1371/journal.pone.0180294.
2. Yuan, Feng, Chao Chen, and Hai-Chao Li. "Effects of AIDET Communication Model on Perioperative Anxiety and Satisfaction in Cataract Day Surgery." Annals of Eye Science 8 (February 2020): 5338. https://aes.amegroups.org/article/view/5338/html.
3. Salman, M., R. Kimball, S. Bromley, T. Belleville, A. B. A. Jabbar, M. Mirza, S. Hayat, A. Sood, and A. Tauseef. "Telemedicine: Future of the Healthcare System and Its Impact on Patient Satisfaction: A Literature Review." Journal of Family Medicine and Primary Care 13, no. 11 (November 2024): 4810–14. https://doi.org/10.4103/jfmpc.jfmpc_830_24.
4. Zolnierek, Kelley B., and Robin M. DiMatteo. "Physician Communication and Patient Adherence to Treatment: A Meta-analysis." Medical Care 47, no. 8 (2009): 826–34. https://doi.org/10.1097/MLR.0b013e31819a5acc.
5. Reader, Tim W., Yasmine Gillespie, Cath Taylor, and Nick Shea. "Patient Complaints in Healthcare Systems: A Systematic Review and Coding Taxonomy." BMJ Quality & Safety 23, no. 8 (2014): 678–89. https://doi.org/10.1136/bmjqs-2013-002437.
6. Naylor, Mary D., Diane Brooten, Rita Jones, Mecit Lavizzo-Mourey, Marian Mezey, and Susan M. Pauly. "Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: A Randomized Clinical Trial." Journal of the American Medical Association 281, no. 7 (1999): 613–20. https://doi.org/10.1001/jama.281.7.613

***Alexis Castro** is a third-year medical student at the NYU Grossman Long Island School of Medicine.*

***Crystal Mehdizadeh** is a third-year medical student at the NYU Grossman Long Island School of Medicine.*

***Aurelio Diaz** is a third-year medical student at the NYU Grossman Long Island School of Medicine.*

***George V. Alvarez, MD** is an attending family medicine physician at NYU Langone Health – Long Island.*

***Donna Montesano, RN** is the Hospital Admin Director for the Department of Family Medicine at NYU Langone Health – Long Island.*

Active Learning Through Multi-System Care Integration: A Collaboration Between Family Medicine Residents and the ARC Senior Center in Washington Heights, New York

By Alexandra Greenberg, MD, MSPH; Ariana Ram, MD and Ana I. Esteban Gonzalez, MD, MEd

Introduction

America is undergoing a population shift, with a growing proportion of older adults who endure the majority of chronic health conditions and are more at risk of and vulnerable to complications from illness and infections.[1,2] At the same time, trust in medicine and particularly preventive care is increasingly under threat.[3] Traditional 15-minute visits are rarely long enough to fully address patients' questions and concerns, particularly in geriatrics, where communication and context are critical.[4-6] This becomes even further complicated when considering older adult immigrants who face additional challenges and barriers in primary care and often have unique needs, beliefs, and preferences.[7]

The New York Presbyterian and Columbia University Family Medicine Residency Program serves the diverse communities of Washington Heights and Inwood, where 72% of residents identify as Latinx and 16% are age 65 or older.[8] Our clinic, the Farrell Community Health Center, is in the heart of what is known as Little Dominican Republic (DR) and the majority of our patients are first or second-generation immigrants from the DR. Many of our patients, especially our older patients, still split their time between the DR and the US, and primarily speak Spanish, reflective of the local population where 36% of residents have limited English proficiency.[8-10] Nationally, Hispanic Americans have poorer health outcomes, which is in large part due to lack of access to primary and preventive care.[11] For non-white Latinx patients in the US, and particularly Dominicans, despite lower rates of hypertension, there are higher rates of uncontrolled hypertension.[11,12] Hispanic American patients also experience lower vaccination rates and lower rates of cancer screening.[11,13] Similar to national trends for Latinx patients, in our local community data demonstrates that 16.3% of residents had no health insurance, more patients relied on public insurance than in surrounding areas, and only 27.3% of men and 31.1% of women received preventive services as of 2023.[14]

Given these disparities, as well as our limited time during visits to tackle many of these issues, further exacerbated by the impact of linguistic and cultural differences, our program has incorporated education about and engagement with the local community outside clinical spaces. Specifically, as part of our Spanish immersion and community medicine advocacy curricula, which residents participate in over the course of their three years, we have established a longitudinal relationship and ongoing projects with a local senior center, ARC XVI Fort Washington.[15] ARC XVI, also located in Washington Heights, serves a predominantly Spanish-speaking older adult population, providing health education, meals, transportation, and a range of supportive services.[15] Our Center for Family and Community Medicine (CFCM) has partnered with ARC XVI for over a decade, working collaboratively to co-develop educational programs and enhance the

continued on page 18

continued from page 17

Center's infrastructure. We contributed to fundraising efforts when the senior center relocated, supporting the construction of a new kitchen and the expansion of its services, reflecting our role as an engaged partner rather than a group consulted only after project planning. Feedback from our prior senior center–based education lectures suggests that small-group sessions are more effective than large lectures, as they promote interaction, knowledge retention, and comfort for both residents and bilingual facilitators. Through our many years of lectures and charlas at ARC XVI, we have seen how embedding residency and medical student programs in these settings creates opportunities for culturally and linguistically informed and tailored health education, while fostering sustained and meaningful community engagement.

With this in mind, this past year we introduced a novel community project for health needs assessment and education in partnership with ARC XVI and its members. This type of programming builds on the well-established practice of community-based participatory research (CBPR), which emphasizes collaboration with community stakeholders, shared decision-making, and the development of interventions with, rather than for, affected communities. CBPR has demonstrated efficacy, particularly when working with marginalized and underserved communities and specifically in relation to chronic disease management and promotion of preventive care, including vaccines.[16,17] This framework not only enhances the relevance and effectiveness of health education for our residents and community members, but is well-aligned with current ACGME requirements, which now more explicitly emphasize the importance of awareness of community resources, context, and partnership and reflective practice in family medicine training.[18]

Through this project, we aim to strengthen preventive health knowledge and uptake, address chronic disease risk, and deepen partnerships that advance equitable care for the Washington Heights and Inwood communities. By engaging family medicine residents in CBPR and applying an active learner methodology through our Encounter-Engage-Reflect model, we can also empower early career physicians to learn from and work in partnership with community members and organizations to more effectively identify and address health needs.

Methods

CFCM family medicine residents have volunteered at ARC XVI for years and helped lead bilingual "charlas", or health education talks, based on health education topics relevant and of interest to the senior center and its members. Based on prior conversations and experiences with ARC XVI during and in response to these charlas, this past July we collaboratively developed and introduced a new project to be implemented by our residents at ARC XVI. Our program has 17 family medicine residents, who participate in our community activities every other week when they are outpatient. During these biweekly sessions, we have conducted two iterations of this project at ARC XVI, which serves over 3,000 older adults annually and reaches approximately, an additional 10,000 individuals indirectly through its programs and community partnerships.[15]

Through this project, we have conceptualized an active learner methodology based on three core phases: Encounter, Engage, and Reflect, to combine experiential learning with structured reflection. This aligns with educational theories describing active learning as intentional engagement, guided observation, and reflection.[19] Reflection strengthens knowledge integration and professional identity.[20] In medical education, active learning improves retention, participation, and problem-solving,[21] though barriers such as time, resources, and faculty training remain.[22] In continuing medical education, strategies like simulations and small-group work improve application.[23] In community-based settings, reflection after real encounters deepens learning and supports professional growth.[24]

Residents first learn about, or encounter, the community by visiting and participating in existing charlas. They then undergo an orientation with our director of community engagement and are split into two groups, at which point they either select a new topic in chronic disease management or preventive medicine to focus on or adapt a prior topic for their charlas. They conduct a review of existing literature and develop a document with background information for their charla topic. They then design a brief survey to elicit knowledge, concerns, and questions from seniors relating to their charla topic. Surveys are translated into Spanish by our bilingual faculty and residents. After this, which takes 1-2 hours, they go to the senior center and pair off to approach and engage seniors, asking if they can discuss their topic with them and offering informal "bilingual charlas". Seniors may participate individually or share their responses as a group, but the survey is completed by all seniors who participate in each charla, regardless of whether it is a group discussion. During the charlas, residents go through the survey with seniors in either English or Spanish and use their background research to address questions and concerns that arise. Residents are paired so each team has a Spanish-speaking member. Afterwards, they ask senior participants to reflect on the impact of their conversation. They then move on to other seniors to complete the same process over the course of approximately 1-2 hours. Once they are done for the day, residents are later asked to reflect on their own experience as well, completing the Encounter-Engage-Reflect cycle.

To date, we have had thirteen family medicine residents and over 30 seniors participate in these charlas. Some residents have participated twice, and in such, we have been able to utilize a scaffolded model for learning, with prior participants using their own experiences and reflections to help teach new participants and inform the development or updating of surveys and background information for charlas.

Results

We have covered three topics: hypertension management, vaccinations, and colon cancer screening, and collected 32 senior surveys and 11 resident reflections. Of the 32 seniors, about three-quarters participated in Spanish-language charlas and one-quarter in English.

Across all survey responses (TABLE 1), seniors consistently rated the educational sessions as either very or somewhat useful, and every participant reported feeling more comfortable discussing the topic with their doctor afterward. Even those who did not learn something new almost always found the sessions valuable and shared specific takeaways. In the colon cancer screening session

continued on page 19

continued from page 18

(N=9), most participants learned something new (89%), and nearly all rated the information as "very useful". Participants highlighted learning about "the importance of these tests," "the risk factors," and the availability of "colonoscopy or Cologuard." One senior noted, *"I thought it was very useful to know about the Cologuard screening that I can do at home."* The vaccine session (N=17) showed similarly strong engagement: 89% learned something new, and most rated the session as "very useful". Seniors emphasized concepts like "herd immunity," "how vaccines work," and that "vaccines are for prevention," with one participant simply responding, *"Everything you said."* The blood pressure session (N=6) produced practical, hands-on learning. Only half learned something new and the majority rated the session as "somewhat useful". However, every participant provided a written takeaway—most commonly about selecting the correct cuff size and understanding normal BP values—showing clear reinforcement of a key, actionable skill despite perceived prior knowledge and rating of knowledge gained.

Across all topics, seniors demonstrated high engagement, strong perceived benefit, and greater confidence communicating with their clinicians, reflecting the value of accessible, community-based health education. Survey findings highlight which topics seniors are most confident in their knowledge about and what information they find most salient.

Written reflections further revealed how meaningful and transformative the ARC sessions were for residents, strengthening their connection to the Washington Heights senior community while expanding their understanding of patient education beyond the clinic. Many described the sessions as rewarding and impactful, noting that seniors were more open and expressive in a familiar community setting than during time-limited office visits. One resident highlighted the shift in dynamic, reflecting on "entering their space in a way that centered their voices and showed that collaboration and trust-building are possible."

A central theme was the value of sensitive, non-judgmental communication. Residents shared that meeting seniors' comments with curiosity helped build partnership: "Framing health advice in a non-judgmental way helps patients feel like partners in their care." Several also noted how family members and support networks shaped seniors' decision-making, prompting reflections on the broader need to rebuild trust in marginalized communities. As one resident put it, the sessions were a reminder of the work needed to "center seniors and their support networks to make decisions for their own bodies." Spanish-language facilitation also played a crucial role; misconceptions shifted once information was explained "in clear Spanish," and one resident emphasized how culturally grounded conversations highlighted "the impact that accessible health education has on promoting proactive, life-saving screening behaviors."

Residents noted seniors' enthusiasm and knowledge, with participants sharing experiences, asking thoughtful questions, and continuing discussions afterward. One resident described it as "refreshing to hear the knowledge and see the excitement the seniors had," while another noted how hands-on teaching, such as demonstrating blood pressure technique, "showed me how empowering knowledge can be." They also recognized limits of informal teaching: not all seniors fully engaged, some responses suggested social desirability rather than true comprehension, and certain deeply held beliefs, especially about vaccines, were difficult to shift in a brief session.

Many residents found the experience personally grounding. Spending time with seniors, hearing their immigration stories, and witnessing how the center fosters connection left a lasting impression. One resident valued "being able to spend more time getting to know these individuals and their stories," while another reflected that the experience highlighted "what is taken away from the doctor's office"—the informal conversations and communal learning that clinical environments often miss. Collectively, these themes illustrate how community-based learning can reshape residents' perspectives on communication, cultural humility, and trust-building, while also deepening understanding of community needs and supporting seniors' engagement with preventive health.

Conclusion

Our early findings suggest that community-based encounters with seniors created a relaxed, collaborative space for bidirectional learning, relationship building, and culturally responsive communication. Using the Encounter–Engage–Reflect framework outside the clinic, residents and seniors co-created practical knowledge (e.g., blood pressure cuff size, vaccine roles) while also revealing gaps in understanding.

A key innovation of our program is its mixed-methods design, pairing senior surveys with residents' structured reflections. This reciprocal approach showed clear benefits—seniors gained practical knowledge and partnership in care, while residents deepened their appreciation for advocacy, trust, and patient perspectives. Current challenges include scheduling, incomplete responses, and limited demographic stratification, which we plan to address as we refine methods and expand data collection. For example, we may trial splitting topic preparation and senior engagement into two sessions to allow more preparation time, build rapport, and increase residents' confidence, though this may reduce resident continuity and require

continued on page 20

TABLE 1 - SENIOR SURVEY RESPONSES BY CHARLA TOPIC

CHARLA TOPIC	Total Respondents	% Learned Something New	% Did Not Learn Something New	Usefulness Ratings	% More Comfortable Talking to Doctor
Colon Cancer Screening	9	89%	11%	8 Very Useful (89%); 1 Somewhat Useful (11%)	100%
Vaccines	17	82%	18%	10 Very Useful (59%); 6 Somewhat Useful (35%) 1 Not Useful (6%)	100%
Blood Pressure	6	50%	50%	2 Very Useful (33%); 4 Somewhat Useful (67%)	89%

continued from page 19

weighing trade-offs. Overall, while the model is still evolving, our early findings suggest this model has utility in promoting primary care by supporting trust and shared knowledge-building.

By moving beyond the clinic and traditional hierarchies, this reproducible Encounter–Engage–Reflect model shows how community engagement can complement clinical care, enhance family medicine training, and strengthen primary and preventive care across New York State.

Endnotes

1. Population Reference Bureau. Fact Sheet: Aging in the United States. Washington, DC: Population Reference Bureau, 2024. https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/
2. Watson, Kim B., Janet B. Croft, Matthew D. Ritchey, and Hua Lu. "Trends in Multiple Chronic Conditions Among U.S. Adults: 2013–2023." Preventing Chronic Disease (2025). https://www.cdc.gov/pcd/issues/2025/24_0539.htm
3. Perlis, Roy H., Jonathan P. Phillips, Scott G. Gulliver, et al. "Trust in Physicians and Hospitals During the COVID-19 Pandemic." JAMA Network Open 7, no. 6 (2024). https://doi.org/10.1001/jamanetworkopen.2024.12345
4. Porter, Justin, Cynthia Boyd, M. Reza Skandari, and Neda Laiteerapong. "Revisiting the Time Needed to Provide Adult Primary Care." Journal of General Internal Medicine 38, no. 1 (2023): 147-55. https://doi.org/10.1007/s11606-022-07707-x
5. Kar, Brajaballav, and Soumyakanta Satpathy. "Trust between Physicians and Older Patients: Review and Qualitative Study." Journal of Geriatric Care and Research 8, no. 2 (2021): 56-64.
6. Sharkiya, Samer H. "Quality Communication Can Improve Patient-Centred Health Outcomes Among Older Patients: A Rapid Review." BMC Health Services Research 23 (2023): 886. https://doi.org/10.1186/s12913-023-09869-8
7. Hawkins, Marina M., Kristen J. Heckrow, Rebecca L. Cortez, and Maria R. González. "Barriers and Facilitators of Health Among Older Adult Immigrants in the U.S." BMC Public Health 22 (2022): 300. https://doi.org/10.1186/s12889-022-03524-w
8. New York City Department of Health and Mental Hygiene. Community Health Profiles – Manhattan 112: Washington Heights & Inwood. Accessed November 17, 2025. https://a816-health.nyc.gov/hdi/profiles/
9. Center for Family and Community Medicine. "About Us." Center for Family and Community Medicine (CFCM), Vagelos College of Physicians & Surgeons, Columbia University. Accessed November 17, 2025. https://www.vagelos.columbia.edu/departments-centers/center-family-and-community-medicine-cfcm/about-us#:~:text=Today%2C%20the%20Family%20Medicine%20at,Puerto%20Rico%2C%20and%20Central%20America
10. Little Dominican Republic. "Home | Little Dominican Republic." Accessed November 17, 2025. http://www.littledominicanrepublic.com/
11. Office of Minority Health, U.S. Department of Health & Human Services. "Hispanic/Latino Health." Accessed November 17, 2025. https://minorityhealth.hhs.gov/hispaniclatino-health.
12. Alvarez, Luisa, Ayana April-Sanders, Priscilla Duran Luciano, Un Jung Lee, Katrina Swett, Cesar Herrera, Donaldo Collado, Robert Kaplan, Franklyn Gonzalez II, Martha Daviglus, Olga Garcia-Bedoya, Tali Elfassy, Neil Schneiderman, Krista M. Perreira, Gregory A. Talavera, Leonor Corsino, and Carlos J. Rodriguez. "Hypertension Prevalence among Hispanics/Latinos of Dominican Background: A Transnational Comparison of HCHS/SOL and ENPREFAR-HAS-17." Global Heart 19, no. 1 (2024): 71. https://doi.org/10.5334/gh.1352
13. American Cancer Society. Cancer Facts & Figures for Hispanic/Latino People 2024–2026. Atlanta: American Cancer Society, 2024. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-hispanics-and-latinos/2024/2024-2026-cancer-facts-and-figures-for-hispanics-and-latinos.pdf
14. The Mount Sinai Hospital. Community Health Needs Assessment 2023. New York: The Mount Sinai Hospital, 2023. https://www.mountsinai.org/files/MSHealth/Assets/MSW/MSM-%26-MSW-2023%20CHNA.pdf
15. ARC XVI Fort Washington, Inc., ARC Fort Washington Senior Center, accessed November 14, 2025, https://www.arcseniors.org
16. Riccardi, Maria Teresa, Valentina Pettinicchio, Marcello Di Pumpo, Gerardo Altamura, Mario Cesare Nurchis, Roberta Markovic, Čedomir Šagrić, Miodrag Stojanović, Luca Rosi, and Gianfranco Damiani. "Community-Based Participatory Research to Engage Disadvantaged Communities: Levels of Engagement Reached and How to Increase It. A Systematic Review." Health Policy 137, no. C (2023): 104905. https://doi.org/10.1016/j.healthpol.2023.104905
17. Ortiz, Kasim, Jacob Nash, Logan Shea, John G. Oetzel, Justin Garoutte, Shannon Sanchez-Youngman, and Nina Wallerstein. "Partnerships, Processes, and Outcomes: A Health Equity–Focused Scoping Meta-Review of Community-Engaged Scholarship." Annual Review of Public Health 41 (2020): 177-199. https://doi.org/10.1146/annurev-publhealth-040119-094220
18. Accreditation Council for Graduate Medical Education (ACGME). ACGME Program Requirements for Graduate Medical Education in Family Medicine. Chicago: ACGME, 2023. https://www.acgme.org/globalassets/pfassets/programrequirements/120_familymedicine_2023.pdf
19. Ben Graffam, "Active Learning in Medical Education: Strategies for Beginning Implementation," Medical Teacher 29, no. 1 (2007): 38-42. doi:10.1080/01421590601176398.
20. Karen V. Mann, "Reflection's Role in Learning: Increasing Engagement and Deepening Participation," Perspectives on Medical Education 5, no. 5 (2016): 259-61. doi:10.1007/s40037-016-0296-y.
21. Fink, L. Dee. Active Learning: A Workshop Handout. Trinity College Center for Teaching & Learning, August 2013. https://commons.trincoll.edu/ctl/files/2013/08/Week-3-Active-Learning.pdf
22. Amber J. Heck, Courtney E. Cross, Veronica Y. Tatum, and Amanda J. Chase, "Active Learning Among Health Professions' Educators: Perceptions, Barriers, and Use," Medical Science Educator 33, no. 3 (2023): 719-27. doi:10.1007/s40670-023-01793-0.
23. Brenda A. Bucklin et al., "Making It Stick: Use of Active Learning Strategies in Continuing Medical Education," BMC Medical Education 21 (2021): 44. doi:10.1186/s12909-020-02447-0.
24. Strauss, Ronald; Mahyar Mofidi; Eugene S. Sandler; Robert Williamson III; Brian A. McMurtry; Linda S. Carl; and Edward M. Neal. "Reflective Learning in Community-Based Dental Education." Journal of Dental Education 67, no. 11 (November 2003): 1234-1242.

__Alexandra Greenberg, MD, MSPH__ is currently a third-year family medicine resident and chief at New York Presbyterian/ Columbia University. Prior to medical school, she worked in global health and completed her MSPH in social and behavioral interventions.

__Ariana Ram, MD__, is a first-year family medicine resident at New York-Presbyterian/Columbia University, where she actively participates in community service programs. She earned her medical degree from the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell.

__Ana I. Esteban-González, MD, M.Ed., CI__, is an Assistant Professor of Community Health at Columbia University Irving Medical Center (CUIMC) New York. She serves as Co-Director of the Community Programs and as Director of the Spanish Clinical Community Elective within the Center for Family and Community Medicine (CFCM).

From Feedback to Function:
How Family Medicine Can Transform Satisfaction Data into Action

By Rodika Coloka-Kump, DO

Patient satisfaction metrics, such as Press Ganey surveys, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and Leapfrog, which addresses hospital performance on patient safety and quality measures, have become powerful drivers of healthcare quality assessment and reimbursement. In family medicine these tools are increasingly influencing how physicians practice, document, and communicate with patients. While designed to promote patient-centered care, the emphasis on satisfaction data has expanded beyond service quality, shaping institutional culture, physician evaluations, and even financial incentives.

In family medicine, where physicians deliver comprehensive and longitudinal care, healthcare quality and patient experience metrics offer actionable information regarding access, communication, and continuity. However, reliance on satisfaction measures as standalone indicators may inadequately capture the complexity of evidence-based clinical decision-making and population-level outcomes. Family medicine leaders should strategically integrate these metrics into quality improvement frameworks—using them to identify communication gaps, inform interdisciplinary workflow redesign, and advance health literacy initiatives—while anchoring evaluation and accountability structures in objective clinical outcomes. When applied as complementary tools rather than primary endpoints, patient experience metrics can reinforce the specialty's policy priorities of patient-centeredness, equity, and value-based care within increasingly transparent and performance-driven healthcare systems.

Over the past two decades, patient satisfaction surveys have evolved from optional evaluative tools into influential components of modern healthcare systems. Instruments such as Press Ganey, HCAHPS, and Leapfrog increasingly shape how clinicians communicate, how organizations allocate resources, and how reimbursement is determined.

As institutions continue to integrate patient experience measures into quality frameworks, family medicine faces a need to reframe the role of satisfaction data. Rather than functioning as punitive performance indicators, these metrics can serve as actionable tools that strengthen communication, improve health literacy, guide systems-based improvements and reduce malpractice claims.

Each patient experience tool captures distinct dimensions of care as outlined below.

Comparison

Domain	Core Question	Perspective	Key Measures
Patient Experience	How did care feel?	Patient	Communication, respect, understanding
Consumer Experience	How easy was the journey?	Consumer	Access, cost, digital navigation
Workforce Engagement	Are staff supported?	Clinician/Staff	Burnout, engage-ment, morale
Safety	Was harm prevented?	System	Errors, infections, adverse events
Clinical Excellence	Was care evidence-based?	Clinical	Outcomes, guideline adherence

Press Ganey focuses on outpatient and inpatient experience, emphasizing communication, access, courtesy, and provider interactions. It addresses patient experience, healthcare consumer experience, workforce engagement, safety and clinical excellence.[1]

HCAHPS—developed by CMS—assesses inpatient experience and directly influences value-based purchasing and hospital reimbursement. It captures the patient's experience of communication with doctors and nurses, the restfulness of the hospital environment, care coordination, responsiveness of hospital staff, communication about medicines, discharge information, cleanliness of the hospital, information about symptoms, and delivers an overall rating, and relative recommendation of the hospital. The survey is administered between 2 and 42 days after discharge to a random sample of adult patients. There are six approved modes of administration: mail, telephone, mail with telephone follow-up, web with mail follow-up, web with telephone follow-up, and web with mail and telephone follow-up. The survey is also available in Spanish, Chinese, Russian, Vietnamese, Portuguese, German, Tagalog, and Arabic translations. Over 4,400 hospitals participate in HCAHPS and nearly two million patients complete the survey each year.[2]

Leapfrog benchmarks safety and patient experience across institutions, with growing emphasis on transparency and consumer decision-making. Leapfrog Hospital Safety Grades are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually. The Safety Grade uses up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources, to produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors.[3]

continued on page 22

continued from page 21

CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) asks patients about their experiences with care from an ambulatory care provider spanning a 6-month period. This reference period allows respondents to consider multiple experiences with care. It is used by medical groups, ACOs and value-based care contracts and includes questions on provider communication, access to care, care coordination, office staff courtesy and helpfulness and shared decision-making.[4]

See Comparison of above satisfaction metrics in Table 1.

Table1: Comparison of Major Patient Experience Metrics Used in U.S. Healthcare

Domain	Press Ganey	HCAHPS	CG-CAHPS	Leapfrog Patient Experience Measures
Full Name	Press Ganey Patient Experience Surveys	Hospital Consumer Assessment of Healthcare Providers and Systems	Clinician & Group Consumer Assessment of Healthcare Providers and Systems	Leapfrog Hospital Survey – Experience of Care Domain
Primary Setting	Hospital inpatient, ED, outpatient, ambulatory, medical practices	Hospital inpatient only	Outpatient ambulatory clinics, medical groups, primary care	Hospital inpatient (public reporting & safety rating program)
Developer / Steward	Press Ganey Associates	CMS & AHRQ	AHRQ (endorsed by CMS)	The Leapfrog Group
Purpose	Internal quality improvement, benchmarking, service recovery	Standardized national measure of hospital patient experience; tied to CMS Value-Based Purchasing (VBP)	Measures patient experience with outpatient clinicians and groups	Grades hospitals on safety & quality; incorporates patient experience into overall score
Data Use	Organizational improvement, provider feedback, practice-level analytics	CMS Care Compare; Value-Based Purchasing adjustments	MACRA*/MIPS* reporting; ACO quality improvement	Publishes annual Leapfrog Hospital Safety Grade
Survey Focus	Service quality, communication, wait times, staff courtesy, overall experience	Communication, responsiveness, cleanliness, pain, discharge information	Access to care, clinician communication, care coordination, office staff performance	Patient experience (via HCAHPS), safety practices, clinical outcomes
Survey Method	Proprietary (mail, phone, email, SMS)	Standardized CMS protocol: mail, phone, IVR, mixed mode	Standardized AHRQ protocol: mail, phone, online	Uses HCAHPS data; additional Leapfrog-collected data
Public Reporting	Not publicly reported (unless voluntarily shared)	Yes — Hospital Compare / Care Compare	Limited public visibility; used by payers, health plans, systems	Yes — Leapfrog Hospital Safety Grade website
Tied to Reimbursement?	Indirectly through internal incentive structures	Yes — Direct CMS VBP payment adjustments	Yes — influences clinician payment through MIPS/ACO participation	Indirectly through contracting, accreditation, and institutional reputation
Key Strengths	Detailed, customizable, real-time analytics	National benchmark; highly standardized	Most relevant for ambulatory care; strong focus on communication	Highly visible; influences public perception and payor decisions
Key Limitations	Proprietary; variable implementation; may emphasize "customer service"	Lagged data; limited to inpatient experience	Survey fatigue; declining response rates	Oversimplifies complex metrics; heavily relies on HCAHPS
Relevance to Family Medicine	Tracks clinic flow, staff engagement, communication quality	Impacts inpatient FM service performance and hospital financial health	Most directly relevant to outpatient FM practice and patient communication	Shapes institutional visibility and residency program reputation

** Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) is a standardized patient experience survey incorporated into the Quality performance category of the Merit-based Incentive Payment System (MIPS), established under the Medicare Access and CHIP Reauthorization Act (MACRA).*

continued on page 23

continued from page 22

For family medicine, these tools provide valuable insight into the patient journey across multiple healthcare environments such as clinic, hospital, and transitional care settings. The metrics especially reflect continuity, communication and access which are essential to high quality patient care.

Surveys exert an expanding influence on healthcare delivery as payors and institutions attach financial incentives to patient experience measures. Satisfaction metrics influence provider evaluations and contract renewals, organizational culture, triage protocols, wait-time expectations, and staffing decisions.

Patient satisfaction surveys are intended to offer valuable insight into patients' perception of care and provide a mechanism for patients to have their voices heard. They can enhance patient-centered care through communication, trust, empathy and shared decision making. They can highlight workflow gaps, such as long wait times and difficulty with scheduling appointments, and identify quality improvement projects and patient safety. Additionally, surveys can trigger improvements in health literacy and patient-friendly, clearer messaging.

However, high satisfaction scores do not consistently correlate with better clinical outcomes, or improved patient safety.[5] These measures can negatively impact evidence-based practice.[6] They have been associated with healthcare overutilization, increased costs and unnecessary tests and overprescribing especially of antibiotics and opioids in an effort to satisfy patients.

Practices with complex patients, behavioral health needs, unstable housing and populations with low trust in healthcare, score lower in patient satisfaction surveys.

Press Ganey and HCAHPS scores are influenced by socioeconomic and demographic factors such as age, race, education, language and health literacy barriers, poverty and social determinants, patient mental health, chronic pain, and stress.[7] Surveys often measure single encounters and miss continuity, relationship-building over time, preventive care counseling, and chronic disease management.[8]

Patient satisfaction surveys may underrepresent the underserved populations. Reports indicate lower response rates for adults who are Black, Hispanic, multiracial, younger and maternity patients. To ensure that the sample reflects the characteristics of the population from which it is drawn, efforts must be made to improve the response rate from these underserved populations.

Survey collection protocols offering only one modality decrease response rates. Typical modalities include: mail only, phone only, mixed mode(mail with phone follow-up) and interactive voice response. Offering two or more collection modes increases the likelihood that patients can respond in their preferred mode and improves the response rate.[9,10]

In patient satisfaction surveys, the timeliness of measurement is an important consideration. Done improperly, significant recall bias can be introduced. For example, the HCAHPS questionnaire is collected within 42 days after discharge, whereas CG-CAHPS is based on visits within the last 6 months.[5]

Sample size is an important factor in comparing scores on surveys and deserves to be recognized and addressed. Low response rates have been shown to be associated with the highest and lowest ratings, reflecting the most highly satisfied or most highly dissatisfied patients. Higher response rates yield more stable estimates, wider score variability, and distributions that produce results that are more representative of typical patient experiences, thereby improving the reliability and interpretability of comparative benchmarks. Failure to account for sample size and response variability may lead to misclassification of performance, particularly in small practices and residency-based clinics. Other factors unrelated to physician performance complicate the interpretation of survey scores. Higher scores are given by patients who are older, have female providers, have positive outcomes, have more complex health issues and generate higher healthcare costs. Established physicians who have developed relationships with their patients over time have higher scores than new physicians. Survey timing is summarized in the Table 2 below:

Table 2 - Summary Table of Timing

Survey Type	When Sent	Response Window	Reporting Frequency
HCAHPS	48 hours– 6 weeks after discharge	6 weeks	Quarterly (rolling 12 months)
Press Ganey Inpatient	1–7 days after discharge	30–42 days	Monthly/weekly
Press Ganey Outpatient	1–3 days after visit	14–30 days	Weekly/monthly
Press Ganey ED	1–7 days post-visit	~30 days	Weekly/monthly
CG-CAHPS	Based on visits in last 6 months	Varies	Quarterly/ semi-annually

To turn feedback into a framework for action, physicians should critically analyze the data and (when justified) highlight opportunities for improvement. The remedial actions available are many. One example is the common patient concerns of feeling rushed, confused by instructions, or unsure about follow-up can be mitigated by structured communication training (motivational interviewing, teach-back), improved agenda-setting at the beginning of visits, enhanced clarity in after-visit summaries, coaching on empathy, tone, and pacing of encounters.[7,11-13]

Another strategy is to enhance your team-based care. This modality can improve the patient experience, increase patient satisfaction scores and enhance efficiency, quality of care and patient safety. The physician leads the care team to build strong relationships with patients. While it is the physician who creates the medical decision-making they should delegate appropriate tasks to well-trained, capable and engaged clinical staff such as medical assistants and nurses. Utilization of brief (5-10minutes) team huddles at the beginning of the day has been shown to improve team communication and sets a shared purpose and agenda.[14] Team-based care can lead to improvements in system-level barriers such as long wait times, unclear front-desk communication, incomplete handoffs and gaps between clinical advice and discharge instructions.[15] Mayo Clinic Arizona defined service values by using the mnemonic "SERVE" for patient interactions.[16] See next page:

continued on page 24

continued from page 23

Value	Description
S – Solutions-focused	Solve problems when and where they occur
E – Empathetic	Treat everyone as you wish you or your family to be treated
R – Reliable	Own the work; if you don't have the answer, find it
V – Valuing others	Protect patient and employee confidentiality
E – Exceed expectations	Contribute to an unparalleled patient experience

Satisfaction scores frequently reflect whether patients understood their diagnoses, medications, and follow-up plans. Simplifying written materials, integrating multilingual resources, using digital tools such as patient portals, secure messaging, and QR-linked educational handouts, and embedding teach-back into routine patient encounters are shown to increase these metrics. Enhancing health literacy strengthens trust, reduces readmissions, and supports shared decision-making.[17] Table 3 outlines potential improvements in quality from survey responses.

Tale 3: Translating Satisfaction Feedback Into Actionable Quality Improvements

Feedback Theme	Common Patient Comments	Actionable Interventions
Communication	"I felt rushed," "I didn't understand my instructions"	Teach-back, agenda-setting, extended AVS materials, resident coaching
Access & Timeliness	"Long wait times," "Hard to reach someone"	Redesign scheduling templates, triage flow, call-back protocols
Care Coordination	"Different answers from different staff"	Team huddles, standardized scripts, improved handoffs
Health Literacy	"Too much medical jargon," "Confusing instructions"	Simplified materials, multilingual resources, QR-coded education
Respect & Empathy	"Provider didn't listen enough," "Seemed uninterested"	Empathy training, reflective practice, communication workshops

Summary

Patient satisfaction metrics, whether derived from Press Ganey, HCAHPS, CG-CAHPS, or Leapfrog, will continue to shape the expectations, workflows, and priorities of modern healthcare systems.

For family medicine, these measures offer both opportunity and challenge. When interpreted thoughtfully, they provide meaningful insight into communication quality, care coordination, health literacy, and system performance across the full continuum of care. When used improperly, they risk distorting clinical priorities, undermining evidence-based practice, and disadvantaging practices caring for medically and socially complex populations. They can become punitive tools.

Family medicine is uniquely positioned to transform these metrics into actionable quality improvements that reinforce the specialty's foundational strengths—continuity, accessibility, empathy, and whole-person care. By reframing patient feedback as a diagnostic tool rather than a judgment, leaders can advance team-based communication, strengthen interdisciplinary collaboration, and champion health literacy initiatives that meaningfully improve the patient experience. Ultimately, satisfaction data should guide growth, elevate both patient experience and the quality of family medicine practice.

Endnotes

1. Press Ganey Associates. *Press Ganey Patient Experience Solutions*. Press Ganey; 2023.
2. Centers for Medicare & Medicaid Services. *HCAHPS Survey: Patient's Perspectives of Care*. CMS; 2021.
3. The Leapfrog Group. *Leapfrog Hospital Safety Grade Methodology*. Leapfrog; 2025.
4. Agency for Healthcare Research and Quality. *Clinician & Group Surveys (CG-CAHPS)*. AHRQ; 2024.
5. Manary MP, Boulding W, Staelin R, Glickman SW. The patient experience and health outcomes. *N Engl J Med*. 2013;368(3):201-203.
6. Fenton JJ, Jerant AF, Bertakis KD, Franks P. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Arch Intern Med*. 2012;172(5):405-411
7. Anhang Price R, Elliott MN, Zaslavsky AM, et al. Examining the role of patient experience surveys in measuring health care quality. *Med Care Res Rev*. 2014;71(5):522-554.
8. Salisbury C, Wallace M, Montgomery AA. Patients' experience and satisfaction with care in general practice: changes with age and chronic illness. *Br J Gen Pract*. 2010;60(572):e365-e372
9. Elliott MN, Brown JA, Hambarsoomian K, Parast L, Beckett MK, Lehrman WG, Giordano LA, Goldstein EH, Cleary PD. Survey Protocols, Response rates, and Representation of Underserved patients: A Randomized Clinical Trial. JAMA Health Forum. 2024;5(1):1–11
10. Anhang Price R, Quigley DD, Hargraves JL, Sorra J, Becerra-Ornelas AU, Hays RD, Cleary PD, Brown J, Elliott MN. A Systematic Review of Strategies to Enhance Response Rates and Representativeness of Patient Experience Surveys. *Med Care*. 2022;60(12):910-918.
11. Bachman JW. The Problem with Patient Satisfaction Scores. *Family Practice Management*. January/February 2016:23-27
12. Boissy A, Gilligan T, et al. Communication skills training for physicians improves patient satisfaction. *J Gen Intern Med*. 2016;31(7):755–761.
13. Agency for Healthcare Research and Quality. Teach-Back: A Health Literacy Intervention. Rockville, MD: *AHRQ*; 2021.
14. Hopkins KD, Sinsky C. Taking Team-based Care to the Next Level. *Family Practice Management*. May/June 2022:25-31
15. Coleman EA, Parry C, Chalmers S, Min S. The Care Transitions Intervention. *Arch Intern Med*. 2006;166(17):1822–1828.
16. Nordum JT, Kennedy DM. Seven Principles for Improving Service and Patient Satisfaction. *Family Practice Management*. May/June 2016
17. Irizzary T, DeVito Dabbs A, Curran CR . Patient Portals and Patient Engagement: A State of the Science Review. *J Medical Internet Research*. 2015 Jun 23;17(6):e148.

__Rodika Coloka-Kump DO, FAAFP__ is Associate Program Director of Saint Joseph's Medical Center Family Medicine Residency Program in Yonkers, New York.

Reclaiming Connection: How Direct Primary Care Transforms the Patient Experience While Preserving Physician Autonomy and Well-being

By Meghan (Yi) Monthie, MD

When my colleagues, patients, friends, and family asked why I resigned from a job I genuinely loved as an outpatient family physician in a large healthcare system, I described it as "death by a thousand cuts." A prior authorization here, a peer-to-peer there, and mounting administrative demands to "fit in just one more patient" slowly diminished my years of learning to care for families with skill, compassion, and integrity to a losing game of managing checkboxes to satisfy insurance metrics and measuring my worth as a physician in relative value units (RVUs). My patients felt it, too – months-long waits for appointments, fragmented care, and a bevy of middlemen and gatekeepers standing between them and the care they not only needed but deserved. Rushed, surface-level, and piecemeal visits create a system of transactional encounters that undermines the essence of the family medicine specialty and erodes the sacred patient/physician relationship.

Realizing that the traditional, insurance-based system was harming my patients as much as it was wearing me down as their doctor was a reality I could no longer ignore. In the fall of 2025, I made the bittersweet decision to leave a job and the families I truly loved caring for, in search of a practice model that honored relationship-based care over volume and profits. As a family physician who recently opened a direct primary care (DPC) practice in September 2025 in Albany, New York, I have seen firsthand how an unhurried, membership-based primary care model can restore what both patients and physicians have been missing: time, presence, and trust.

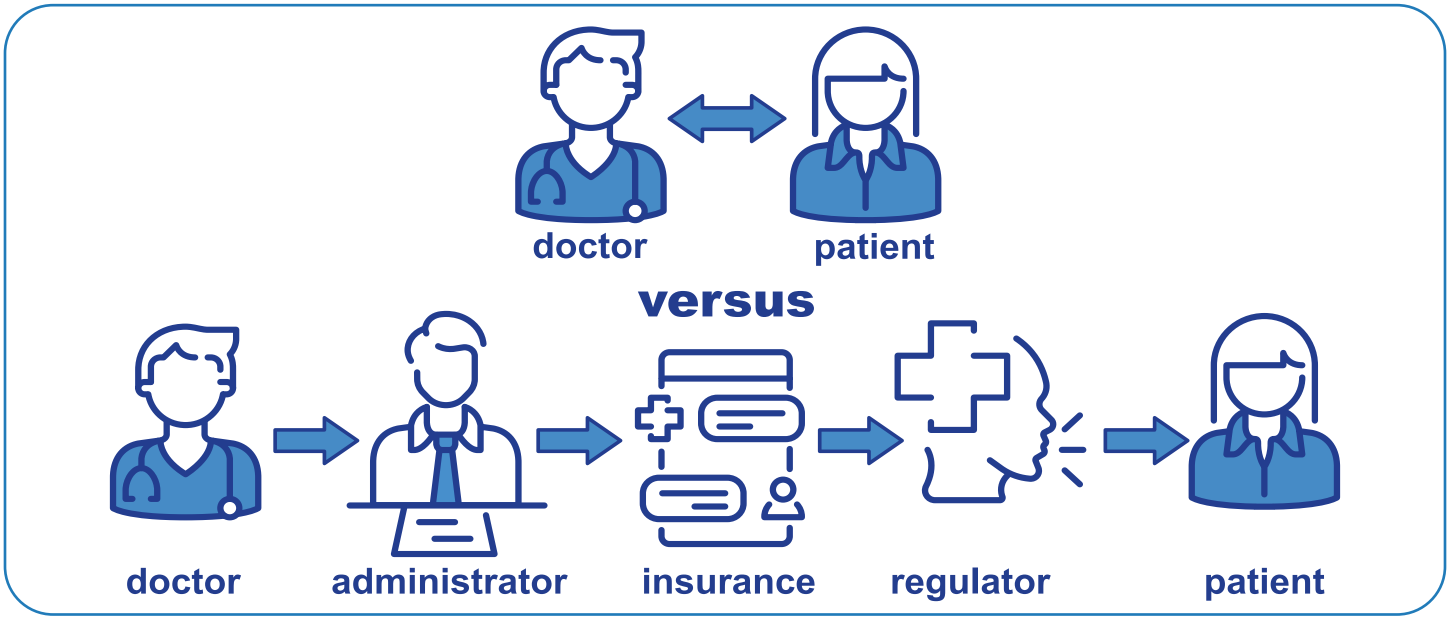
My anecdotal experience isn't an outlier. All across New York State and the broader United States in all types of neighborhoods and communities, family physicians are rediscovering the joy and meaning in their work by removing insurance and health system barriers from the exam room through the DPC model. Patients, too, feel the difference immediately. With fewer barriers to care and more access to their doctor, a visit to the clinic becomes something deeper: a partnership built on time, trust, and genuine understanding that can lead to greater adherence to care plans, an overall decrease in healthcare costs, and greater satisfaction on both sides of the exam table.[1]

The purpose of this article is to highlight how the DPC model improves the patient experience as well as supports physician well-being and autonomy. It will also address the common misconceptions about and unique challenges that family medicine and other primary care physicians in New York State may encounter in the DPC model.

What is Direct Primary Care (DPC)?

DPC is a membership-based healthcare model in which patients pay a predictable monthly or annual membership fee that covers the vast majority of their primary care needs: preventative care, chronic disease management, acute visits, many in-office procedures, and in some cases, even obstetrics services. Because DPC practices do not bill health insurance for their services, they avoid many of the administrative complexities associated with insurance-based reimbursement. This paradigm shift sub-stantially reduces overhead costs related to billing infrastructure, robust support staff,

continued on page 26



continued from page 25

and claims management, thus allowing DPC practices to operate with leaner staff and straightforward payment systems. This operational efficiency allows physicians to redirect their time and resources directly toward patient care rather than burdensome administrative tasks chasing reimbursement. Monthly membership fees vary greatly depending on geographic location and services provided ranging from $60-250/month.[2,3]

While DPC membership includes most primary care services, it does not cover non-primary care services, such as laboratory tests, imaging, specialist consultations, urgent care, emergency care, or hospitalizations. In most states, DPC practices are able to negotiate low, "at-cost" pricing for common lab and imaging services, thereby improving price transparency and reducing overall out-of-pocket costs for patients. Under these arrangements, commonly ordered tests such as a complete blood count (CBC), comprehensive metabolic panel (CMP), and lipid panel may cost as little as $2-8 per test. However, New York State law prohibits these direct lab discount models that are permitted in many other jurisdictions, limiting potential cost-savings opportunities for patients.[4-5] For DPC patients in New York with health insurance, diagnostic testing and higher ticket items outside of the scope of primary care may be billed through insurance in the usual manner. Uninsured DPC patients in New York may access discounted self-pay pricing through national lab companies, with approximate prices of $20-30 for a CBC, $13-30 for a CMP, and $20-40 for a lipid panel as of this publication.[6-8] DPC doctors can also help uninsured patients navigate self-pay pricing for other healthcare needs such as surgeries and specialist procedures that would typically be processed through insurance.

Importantly, in contrast to concierge medicine practices in which physicians also bill health insurance in addition to their retainer fee, DPC does not "double dip." DPC practices do not bill insurance for covered services, and membership/retainer fees are generally less cost-prohibitive than those of concierge practices, making DPC a realistic option for a wider range of patients.

While each DPC has its own unique offerings, common key features of the DPC model include:

- *Smaller patient panels:* Because revenue comes from membership fees rather than per visit billing, DPC physicians can maintain far smaller patient panels (400-600 patients in DPC, compared with 1800-2500 patients in traditional insurance-based settings). By numbers alone, this dramatically increases access to and continuity of care.
- *Longer appointments:* Office visits typically last 30-60 minutes, rather than the typical 10-20 minute slots dictated by insurance-based, volume-driven throughput. This allows greater opportunities for longer evaluations, lifestyle counseling, addressing multiple concerns, and reducing unnecessary specialist referrals due to lack of time.
- *Direct communication:* Patients have direct access to their physician via phone, text, secure message, and/or email, reducing barriers to communication with their doctor and permitting real-time guidance for patient concerns. Coverage for after hours, holidays, and vacation varies among practices, but most DPCs provide some level of access (usually via phone or telemedicine) in these situations.
- *Administrative simplicity:* Without third-party billing, the administrative burden (and associated cost) plummets as a result of less paperwork and fewer claims aimed solely at meeting billing requirements for maximum reimbursement.

An Improved Patient Experience

Patients who choose DPC consistently describe a primary care experience that feels more accessible, personal, and trustworthy.[9] Frequently touted advantages that patients enjoy in the DPC model include:

- *Access and convenience:* Patients in the DPC model report better availability including same/next day scheduling for acute needs, extended visit times, and more streamlined communication with their physician who knows them through convenient means of communication such as text, phone, e-mail, or secure messaging. Additionally, there is a reduced reliance on urgent care clinics and emergency rooms for care that could appropriately be handled in the PCP office because of the enhanced availability of appointments, attention to follow up, and focus on preventative care.
- *Continuity of care:* With smaller patient panels and leisurely appointment times, patients see their own doctor at every visit, not whichever physician or non-physician provider happens to have availability that day. This eliminates the fragmentation so pervasive in traditional systems that leads to frustrating games of "telephone" and unsafe transitions of care. The result is a deeper, more enduring patient/physician relationship that supports stronger adherence to care plans, better preventive care, and improved chronic disease management.
- *Affordability and transparency of cost:* Membership-based care offers predictable pricing with no surprise bills months after services are rendered or confusing insurance explanations of benefits. While the Affordable Care Act originally required individuals to carry health insurance, the federal penalty was eliminated in 2019, and New York State does not have a state-level mandate. With the trend of increasing insurance premiums and deductibles, some patients are dropping insurance altogether, and DPC offers access to high-quality everyday care at a fraction of the cost.[10-12] For catastrophic coverage at a more affordable rate, some DPC patients opt to enroll in health sharing plans which tend to have lower monthly costs than those of traditional insurance plans. Even for insured patients, the transparency and simplicity of the DPC model are appreciated.
- *Patient satisfaction and perceptions of quality:* Qualitative studies interviewing DPC patients uncover common themes: improved communication, a stronger personal connection with their physician, and easier access to care. Patients frequently cite feeling "heard," "known," and "prioritized," sentiments that are increasingly rare in traditional high-volume primary care settings.[9]

continued on page 27

continued from page 26

An Improved Physician Experience

DPC not only improves the patient experience; it meaningfully reshapes the professional lives of family physicians. In a specialty where burnout is widespread, DPC addresses several core drivers of professional distress in our specialty:

- *Reduced administrative burden:* In traditional fee-for-service practice, an enormous share of a physician's day is consumed by documentation, billing requirements, and insurance-related tasks. The American Academy of Family Physicians estimates that nearly 50% of physicians' work is tied to billing-driven documentation alone. In DPC, removing insurance from the exam room means dramatically fewer forms, prior authorizations, and box-checking. That time is reclaimed and reinvested into clinical care, patient relationships, and the meaningful work that drew many of us into medicine.
- *Restored clinical autonomy:* Without insurance rules dictating visit length, coding levels, or which services are medically necessary or "count," physicians can practice medicine based on their clinical judgment, not billing constraints. This allows for longer visits, thoughtful follow-up, and creative care delivery such as home visits, asynchronous care, extended counseling, and flexible scheduling. The result is a return to physician-led decision making rather than insurer-led gatekeeping.
- *Improved work/life balance:* Smaller patient panels translate into fewer inbox messages, fewer after-hours documentation demands, and more control over your schedule. DPC physicians often report the ability to reliably protect time for their families, personal health, and rest without sacrificing the quality of care their patients receive.
- *Lower burnout and higher professional fulfillment:* A 2024 comparative study found that DPC physicians reported significantly lower burnout and higher professional fulfillment than their non-DPC counterparts, even though both groups worked similar total hours. DPC doctors also saw fewer patients per day, had more ownership over their work, and expressed greater confidence that they were practicing medicine in alignment with their values.[13-16]

Common Challenges and Misconceptions

Common criticisms of DPC include:

"DPC is only for the wealthy."
While some concierge practices set fees that may be out of reach for many patients, most DPC clinics intentionally build models that promote equitable access through more affordable rates as well as sliding scale, subsidized, pro bono, and employer-sponsored memberships. As a practice grows, so does its capacity to balance financial sustainability with a commitment to inclusivity. Some DPCs are even structured or supported by associated non-profit organizations focused on and dedicated to caring for vulnerable and underserved populations.[17-18]

My own patient panel includes individuals across a wide spectrum of socioeconomic backgrounds and insurance types, including patients who are commercially insured through employer-sponsored and New York State marketplace plans, Medicare and Medicaid beneficiaries, and uninsured. Of note, physicians who plan on caring for patients with Medicare must submit a formal opt-out affidavit to the Centers for Medicare and Medicaid Services and enter into a private contract with Medicare beneficiaries. There is no similar requirement to care for Medicaid beneficiaries in the DPC model.

Beginning January 1, 2026, Health Savings Accounts (HSAs) may be used for DPC membership fees (up to $150 per month for individual plans and $300 per month for family plans), leading to greater affordability and accessibility for patients with high deductible health insurance plans.

"DPC is worsening the primary care shortage."
This criticism deserves thoughtful consideration, but it often overlooks an uncomfortable truth: the primary care workforce is already shrinking under the traditional fee-for-service system. Burnout rates among primary care physicians remain among the highest in medicine, and many clinicians are reducing hours or leaving practice altogether.[19]

When nearly half of a physician's workday is spent on uncompensated administrative tasks, I have to ask - do we truly have too few primary care doctors or do we have too much administrative burden? By improving professional fulfillment and extending career longevity, DPC arguably helps preserve primary care capacity in the long run rather than diminish it.

"New York State has too many regulatory challenges."
DPC practices in New York State face unique regulatory and operational challenges not present in other states, such as restricted access to direct client billing labs and in-office medication dispensing which can offer significant cost-savings for patients. These challenges present meaningful opportunities for advocacy and policy reform to strengthen the prospect of DPC and expand access to more affordable health care for New Yorkers.

Still, the heart of the DPC model has never been discounted prices. Rather, it is about time, access, and the restoration of meaningful patient/physician relationships. In my experience, these regulations rarely discourage patients who are seeking continuity, communication, and comprehensive care.

"But I don't want to be on call all the time."
This is one of the most common fears among physicians exploring DPC, as well as one of the biggest misconceptions of the model. The relationship-based nature of DPC fosters mutual respect, including respect for boundaries. Patients no longer feel pressured to call after hours just to get timely advice because they can reliably reach their physician during the day. And when patients do reach out, it's usually appropriate and rarely intrusive. Paradoxically, DPC physicians report *fewer* after-hours disruptions than they experienced in the traditional system, not more.

continued on page 28

continued from page 27

With regards to planned time off (such as holidays, vacations, and maternity/paternity leave) and unexpected time off for illness, DPC physicians can share coverage with other doctors in their clinic or nearby DPC and private practice clinics. Thoughtful and proactive scheduling and outreach in advance of planned absences also ensure that patients receive appropriate and uninterrupted care even when their doctor is out of the office.

Conclusion

Reclaiming connection in family medicine isn't a nostalgic, pipeline dream; it's a practical, achievable path. DPC offers family physicians a tangible way to restore joy in clinical practice, reclaim autonomy, and return to the heart of our profession while simultaneously improving the healthcare experience for patients. In this unhurried, membership-based DPC model, presence becomes the default, not the exception. And in that elusive yet worthwhile space, the relationships, trust, and meaningful impact can begin to grow again.

Endnotes

1. Tecco, H., Rahim, F.O., Lalwani, P. et al. Direct Primary Care: Financial Analysis and Potential to Reshape the U.S. Healthcare Landscape. J GEN INTERN MED 40, 448–452 (2025). https://doi.org/10.1007/s11606-024-09038-5
2. Eskew PM, Klink K. Direct Primary Care: Practice Distribution and Cost Across the Nation. J Am Board Fam Med. 2015;28(6):793–801. doi:10.3122/jabfm.2015.06.140337
3. Society of Actuaries. Evaluating a New Model of Care: A Financial Analysis of Direct Primary Care. Schaumburg, IL: Society of Actuaries; 2020. Accessed November 16, 2025. https://www.soa.org/globalassets/assets/files/resources/research-report/2020/direct-primary-care-eval-model.pdf
4. Direct Primary Care Frontier. New York. Direct Primary Care Frontier. Accessed November 16, 2025. https://www.dpcfrontier.com/new-york
5. Reynolds LQ. The Direct Primary Care Model: Considerations for New York Providers, Patients, and Employers. Health Law J. 2024;29(1). Accessed November 16, 2025. https://www.mintz.com/sites/default/files/media/documents/2024-01-23/HealthLawJournal_2024_Vol29_No1.pdf
6. "What Does Direct Billing Mean and How Does It Work?" LegalClarity, December 6, 2025. https://legalclarity.org/what-does-direct-billing-mean-and-how-does-it-work/
7. Labcorp. 2024. *LabAccess Partnership (LAP): Access to affordable health care is widely recognized as a national issue*. PDF.
8. Labcorp. "What is the LabAccess Partnership program and how does it work?" Accessed December 14, 2025. https://patient.labcorp.com/help-center/q-and-a/4000/14
9. Tou LC, Jeyakumar SJ, Siddiqui TA, Ravi S, Prakash N. Understanding Patient Perceptions Towards Direct Primary Care: A Focus Group Study. J Patient Exp. 2022;9:23743735221117359. Published 2022 Aug 1. doi:10.1177/23743735221117359
10. CNBC. "Premiums for Employer Health Insurance Have Jumped 47% in 10 Years." *CNBC*, November 11, 2021. https://www.cnbc.com/2021/11/11/premiums-for-employer-health-insurance-have-jumped-47percent-in-10-years.html.
11. The Commonwealth Fund. "New State-by-State Report Finds Workers' Health Insurance Premiums and Deductibles Continue to Rise." *The Commonwealth Fund*, 2022. https://www.commonwealthfund.org/press-release/2022/new-state-state-report-37-states-workers-health-insurance-premiums-and.
12. Cohen, Joshua. "Health Insurance Premiums to Rise Well Above Inflation for Most Americans." *Forbes*, September 11, 2025. https://www.forbes.com/sites/joshuacohen/2025/09/11/health-insurance-premiums-to-rise-well-above-inflation-for-most-americans/.
13. Brekke G, Onge JS, Kimminau K, Ellis S. Direct primary care: Family physician perceptions of a growing model. Popul Med. 2021;3:21. doi:10.18332/popmed/140087
14. Boylan ME, Hurley DM. Comparison of Burnout and Fulfillment Rates between Physicians in Direct Primary Care and Other Practice Models. South Med J. 2025;118(5):275-280. doi:10.14423/SMJ.0000000000001821
15. American Academy of Family Physicians. Adopting direct primary care using a DPC membership management system: AAFP Innovation Labs Report – Phase 1. Leawood, KS: AAFP; 2022. Accessed November 16, 2025.
16. American Academy of Family Physicians. 2024 Direct Primary Care Data Brief. Leawood, KS: AAFP; 2024. Accessed November 16, 2025. https://www.aafp.org/dam/AAFP/documents/practice_management/direct-primary-care-2024-data-brief.pdf
17. Healing Grove Foundation. n.d. Who We Are. Accessed December 14, 2025. https://foundation.healinggrove.org/about/#who-we-are
18. Black Young Justice Alliance. n.d. Home. Accessed December 14, 2025. https://byja.org/
19. Eskew P. In defense of direct primary care. Fam Pract Manag. 2016;23(5):12-15. Accessed November 16, 2025. https://www.aafp.org/pubs/fpm/issues/2016/0900/p12.html

***Meghan (Yi) Monthie, MD** is a family medicine physician and owner of Heirloom Family Medicine, a direct primary care practice that cares for busy women and multiple generations of their families in Albany, New York. Dr. Monthie is thankful for the opportunity to care for patients of all backgrounds and with all types of health care coverage as well as her own family with more presence, connection, and heart through the DPC model. Connect with her on Instagram @meghanmonthiemd or via e-mail at drmonthie@heirloomfamilymed.com.*

Clinical Emergency Preparedness
in the Ambulatory Setting

By Elaine Schaefer, DO; Nancy Beran, MD, MHCDS; Lora Giacomoni, RN; Arvin Maala, RN and Angela Cressman, RN

Overview

Instances of clinical emergencies in physician offices can vary widely, and benchmarking data are elusive to come upon. Clinical emergencies are taxing for patients, team members, and providers. By ensuring training protocols are in place, we can create an efficient, safe, and organized response and significantly improve overall outcomes for patients.

About Northwell

Northwell Health stands as New York State's largest healthcare provider, an expansive integrated system encompassing 21 hospitals and over 850 outpatient facilities, dedicated to delivering comprehensive, high-quality care across a full spectrum of medical specialties. Its commitment extends from advanced tertiary services to essential community health initiatives, serving millions annually. Central to Northwell's patient-centric model and its strategic vision for accessible healthcare delivery is its robust and continuously expanding ambulatory network. This extensive footprint includes primary care practices. By prioritizing outpatient services, Northwell Health not only enhances convenience and reduces costs but also fosters proactive health management and ensures seamless continuity of care, solidifying its role as a leader in modern healthcare delivery. However, rapid ambulatory growth in the scope of care and complexity of patients is not without inherent risk.

Introduction

Patient safety is a priority in all locations of our health system. With our aging population, we will continue to see sicker and more clinically complex patients in the ambulatory setting. By being ready for clinical emergencies, physician offices can ensure they provide the highest standard of care, protect their patients, and maintain a safe and effective practice environment. Additionally, staff who feel better prepared to handle emergencies may avoid experiencing moral injury following a clinical emergency.

Patients may experience myriad clinical emergencies while seeking care at ambulatory practice sites. These include falls, severe asthma attacks or respiratory distress, seizures, loss of consciousness, anaphylaxis, myocardial infarction, stroke, drug overdose, severe hyper/hypotension, hypo/hyperglycemia, and even cardiac arrest. Over 100 patients are transferred to a higher level of care from our ambulatory sites per year. Many of these patients arrive at the practice in a decompensated state. Team members need to be alert and ready to both identify and respond to these types of emergencies. Our ambulatory offices are staffed with a mix of licensed and unlicensed individuals who do not often see and are not trained to manage emergency situations. Further, employee turnover, limited current training, and the variety of clinical settings make clinical emergency readiness a challenging task.

Implementation

We set out to create a clinical emergency response readiness program for our practice sites. Our key steps included:

- Identified and collated all ambulatory-specific policies, documentation, procedures, team trainings, and protocols related to readiness for review.
- Created a workgroup to determine best practice surrounding urgent/emergent clinical escalation and response.
- Created and implemented training modules across teams.
- Established participation with pilot locations within the Family Medicine Service Line.
- Created a training program that could be sustained and rolled out on a broader scale across all ambulatory sites.

Ultimately, the above components culminated in the key deliverable and goal: the development of an Ambulatory Clinical Emergency Readiness Program Playbook.

The workgroup required some training prior to implementation. Availing ourselves of system education, we were able to provide simulation training and, most importantly, techniques in effective debriefing. We then set out to create a preparedness program that included regular role-based emergency training for all team members. Through the program, team members participated in an ambulatory emergency simulation to provide staff development in identifying team roles, learning the location of emergency equipment, and ensuring proper response protocols were implemented to transfer care safely and effectively to EMS.

We began with a subset of sites to implement and evaluate the project. A survey tool was created to better understand how our team members felt regarding their level of preparedness. Each practice site team was surveyed prior to receiving education and training.

We started small, collaborating with our pilot sites to ensure the training and associated documents were thoughtful, easy to use, and well received. This allowed us to refine our

continued on page 30

continued from page 29

program prior to releasing it on a larger scale. This process took approximately 10 months to complete.

Once our training program was optimized, we rolled it out on a larger scale. Both pre- and post-surveys were administered to team members to determine the training's effectiveness, and an Ambulatory Readiness Program Playbook was developed for future reference.

Methods

The initial on-site training program utilized a two-phased approach for all clinical and non-clinical team members. Regular opportunity for reinforcement of learning was then provided. The first one-hour session combined an exploratory component, designed to assess team members' existing knowledge and perceived readiness for clinical emergencies, with a didactic segment. This instruction covered the definition of an acute ambulatory emergency and detailed "Code Blue" activation. The protocol specifics included location details (e.g., "Code Blue Room 3") to ensure clear and concise activation of the emergency preparedness plan. Additionally, the didactic training addressed the identification and proper utilization of emergency equipment, defined team roles and responsibilities for safe patient management during crises, and efficient transfer of care to emergency medical services (EMS).

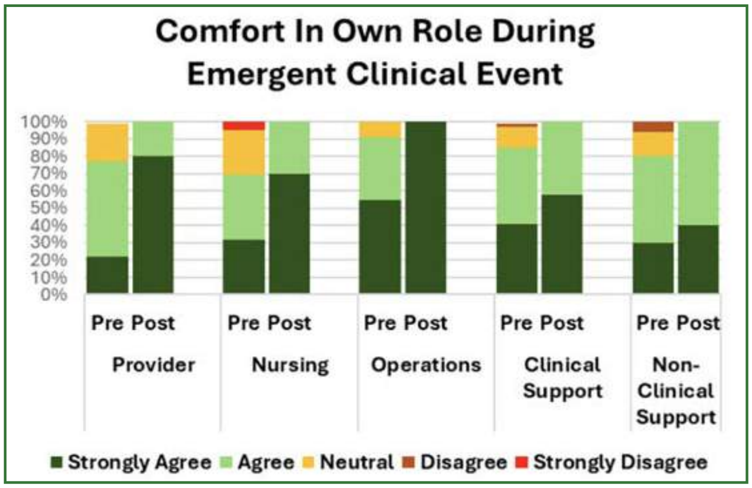
Emergency Response Team Roles and Responsibilities Reviewed:

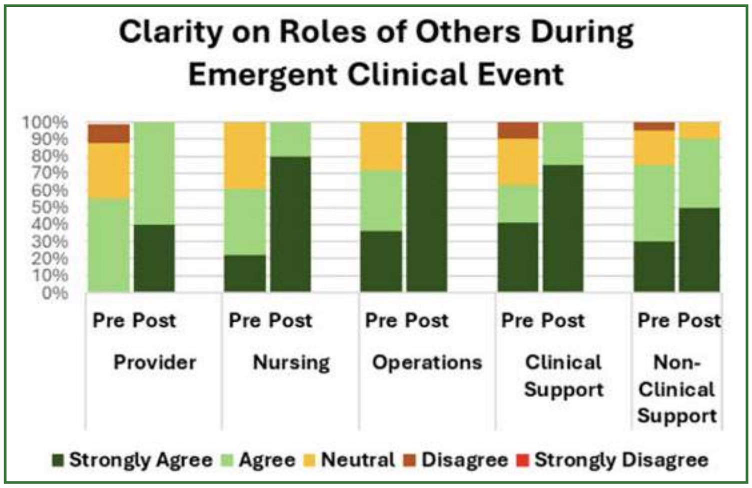
- Clinical Response Team – those who will care for the patient
- EMS Activation/Greeter – team member who will contact EMS and bring them to the patient location
- Crowd Controller – team member who will surveil the waiting room
- Emergency Hand-off Document Preparer – team member who will print the chart
- Obtaining Emergency Equipment and Supplies / AED – team member who will gather necessary supplies
- Communication with Family/Emergency Contact – team member who will call/remain with family
- Reporting of Occurrence – into the system event reporting platform
- Debriefing Session – all team members
- Maintenance of Emergency Supplies – team member who will restock emergency supplies

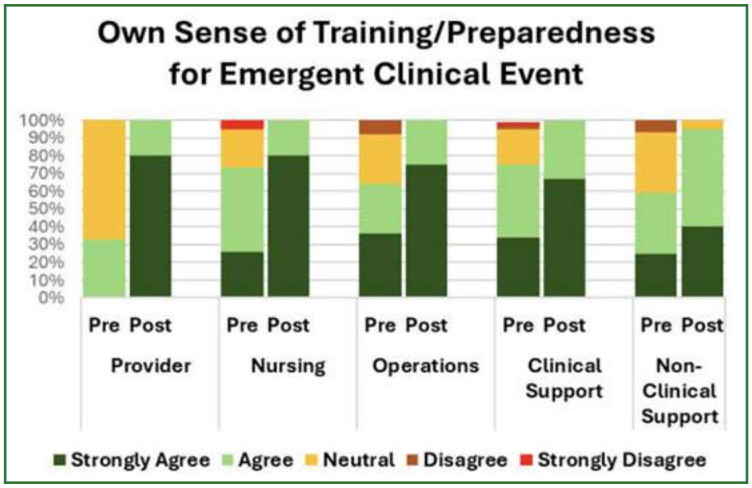
The second one-hour session subsequently provided participants with the opportunity to engage in a simulated emergency scenario to provide staff development in communication, teamwork, and emergency management, concluding with a comprehensive debriefing. Team members were also advised that as soon as possible after an actual emergency, a debriefing session should take place within the office. During this time, reflection and feedback should be aimed at improving and sustaining future performance should another event occur. Teams are encouraged to discuss what went well and where there may be room to improve performance and response time in the future.

Data

The three charts below consistently illustrate a positive impact of the training reflected in the "Post" data across the various roles concerning emergent clinical events across seven sites involved in the initial rollout. Specifically, there is a noticeable increase in reported comfort in one's own role, clarity on the roles of others, and an improved sense of training/preparedness following the training. All roles, including providers, nursing, operations, clinical support, and non-clinical support, demonstrated a shift towards higher agreement and lower disagreement or neutrality in the "Post" phase for all three measures. The most significant gains are in "Own Sense







continued on page 33

Informed Consent and Shared Decision-Making in Clinical Visits to Optimize Patient Experience

By Lisa Morrow, NP, LAc and Robert Morrow, MD

Introduction/Overview

Four articles that consider a spectrum of consent, shared decision-making and medico-legal frameworks are referenced throughout this article. While patient preference may vary from person to person, a positive medical visit often means the patient directs the visit, can understand what they're being offered and can exchange ideas with their clinician. As the conversations unfold, the clinician learns what the patient prioritizes and decides whether the clinician feels comfortable with those priorities.

Comparing patient-weighted priorities to provider-weighted priorities is an important part of shared decision-making. The provider role is to inform, not intimidate, and to create a tone for the visit that aligns with the patient's needs and preferences. Patient centered care – that asks the patients to share their perspective, their opinion, their preference – is not only good for quality care, it is also is good customer service. In the presence of uncertainty in a differential diagnosis, or a poor prognosis, the clinician and patient will have to decide together how much the patient wants to know regarding risk. The patient should leave a visit feeling they have been listened to, but it is also true that listening to a patient is best medical practice when making a diagnosis. How much technical detail a clinician shares, especially regarding risk, is dependent also on how much information the patient would like the clinician to share.

Steps to facilitate an open exchange include the clinician respectfully pausing to check in at various points throughout the visit – both to consider how the patient is perceiving the visit in real time and the patient's options for next steps. Active listening will increase the likelihood of patients returning, adherence to clinical best practice, and adherence to best medical legal practice.

Characterizations of Consent

Several family medicine physicians discuss the concept of consent across a spectrum including consent, assent and nondissent in their article titled, "The Consent Continuum: A New Model of Consent, Assent, and Nondissent for Primary Care."[1]

Notably, in clinic visits, weighted values of consent pertain to specific protocols. Invasive procedures require traditional signed documents of consent for the patient and clinician to keep on record. With lower risk interventions, a clinician may proceed with conversation and absence of dissent. When the patient presents for the visit, this could be considered "implied consent" regardless if they initiated the visit themselves or if there was shared decision-making in a previous visit for a return. A patient's presence in the waiting room implies consent for a visit. In most clinical settings, patients expect vital signs to be measured upon arrival, and perhaps blood to be drawn. These expectations can be considered "nondissent". The authors consider a phlebotomy visit, if the patient presents to the visit and rolls up a sleeve and proffers a limb, this can be considered a body language form of agreement. However, the patient may have an expectation based on prior visits and have not realized they do not *have* to get blood drawn (or agree to vitals, or present to the visit at all).

There are different time parameters and expectations for different types of clinical consults and visits. A patient arriving for talk therapy is unlikely to expect their blood pressure to be measured or to have physical contact with the therapist. A primary care visit or specialty consult is typically 15-20 minutes where a talk therapy visit may last up to 120 minutes. A patient presenting for a surgical procedure likely had a consultation prior with the surgeon and may not see the surgeon on the day of the procedure. However, clinicians/staff do not ask the patient prior to or during the visit how much time they prefer to spend in the visit.

Patient preferences vary regarding how their medical visit unfolds.[2] On one polarity, a patient may prefer a paternalistic interaction where the clinician has the authority to both advise and make decisions unilaterally. On the other polarity, patients may prefer that the clinician explain and educate about options and conditions and let the patient ask questions so the patient can make their own decisions. Shared decision-making is the conversation the patient surfaces regarding their preferences between these two

continued on page 32

continued from page 31

polarities. The relationship between a clinician and patient can evolve along this continuum over time with continuity of care. Regardless of the weight placed on the clinician or the patient's choices, the conversations will involve features of sharing information, processing the information and making decisions. Patients may want to be involved in decision-making, and the onus is shared between the clinician and patient to open the discussion. Coos Engelsma also makes the points:

> *"a paternalistic process in which only the physician provides information about the disease and treatment options, adduces arguments, proposes a choice, etc., may still lead to a decision with which the patient fully agrees (cf. Charles et al. 1997, 688). Also, it is imaginable that a shared process leads to a decision that is not shared or only minimally shared"*[3]

The Visit and Treatment Plan

There is a wide range of normal for a clinician practicing well within standard guidelines regarding how they create space for questions and explain the type of a physical examination. Common and expected task flows in a clinical visit occur before treatment or management options are considered. While shared decision-making typically infers treatment options, it could be expanded to include the architecture of the entire visit. "Shared decision-making is a process in which healthcare professionals and patients work together to select tests, treatments, management, or support packages, based on clinical evidence and the patient's values and informed preferences."[4]

Sharing decisions can be an umbrella that reframes the entire visit. For many clinicians, the clinic visit follows a template, with small variations based on the chief complaint and clinic type. The more a clinician practices across visit types, a pattern emerges; there is an oral history, a physical examination and documentation of the visit. Orders are placed for imaging, laboratory workup and perhaps additional referrals. A patient coming in may not have a clear idea how the visit will progress. Details of explanation may vary between clinicians. From the clinician perspective, they may not have explicitly considered how much of the routine visit is voluntary (i.e. what questions are being asked and need to be documented) once the visit has started, and how much of it needs to be explained before proceeding with routine actions. Shared decision-making can also be seen as a way for clinicians to distance themselves from risk associated with outcomes- since the patient will have made the decision themself.

Once shared decision-making and the dynamics of the patient provider relationship are applied to treatment plans, Engelsma delineates further considerations.[5] Using the example of how to treat an early appendicitis, the article discusses how a clinician might lean towards the quickest way to ensure safety such as laparoscopy, while the patient might wish to avoid surgery and take an antibiotic first. Given five available options (laparoscopic surgery, open surgery, probiotics, antibiotics, or "watch and wait") there are many permutations about how a clinician might rank the options and how much weight they would give each. The patient also has many permutations to rank and weight treatment options. A comparison of the weight and ranking of options between clinician and patient may create more challenges. Most visits are scheduled for 10-20 minutes, so the time needed to plot the conversation, review the options available, then rank and weight them before comparing preferences would likely take more than the allotted time. If the patient and clinician are not in agreement but wish to continue working together, they may defer a decision until the next visit, the provider may take additional time to research additional options, or the patient may seek additional opinions without terminating the relationship.

Legal Considerations

Arvind and McMahon introduce some very interesting legal angles in their 2020 article "Responsiveness and the role of rights in medical law: lessons from Montgomery."[6] The article reviews precedent from the 2015 case *Montgomery verse Lanarkshire Medical Board*, in which an OBGYN physician was found negligent for not having disclosed to the patient/ family the material risk (to the baby) of a vaginal delivery. Injuries sustained to the baby resulted in lifelong disability that could have been avoided if the mother was given more information. There was evidence the mother would have chosen a caesarean section if she had the missing information. The case set a precedent to update the framework for a clinician and patient interaction to move away from paternalistic and towards a consumerist model.

The new medical laws set the stage for patients to make their own decisions based on information from their providers. Providers may struggle with relaying statistical risk or possible poor outcomes. The clinician-patient relationship is hopefully built on trust: creating a functional dynamic to discuss challenging information and ever improving medical options. The medico-legal framework highlights that patient needs as well as medical practice change, and application of legal updates is nuanced. Framing conversations with patients that make space for questions and answers and that include loved ones when applicable, afford dignity to the patient as a stakeholder in their own health. Medical knowledge is publicly accessible today in ways that were not available in the past. Curating and understanding information that is readily available to all patients is a relatively newer dynamic of healthcare. Providers may feel that discussing risk and possible negative outcomes reduces healing potential. Other providers and patients may believe the negative conversation is offset by the healing potential of patients making informed decisions. Sometimes the patient disagrees with the clinician's analysis and that must be clarified by asking; "does this make sense to you?"

There are many questions to further explore centering medical decisions and visits solely around a patient's medical needs. Has the pendulum from paternalism swung too far in the other direction? If the patient retains exclusive decision-making rights, this also impacts the medical experts. The lawyers reflect on a "socially responsive model" that works empirically and not just theoretically to support patient autonomy and allow for clinical expertise and trust in a patient clinician relationship. The distance between professional medical norms and medical law is something that

continued on page 33

continued from page 32

warrants regular updates to ensure that consumerism does not override professional expertise or medical ethics.

Conclusion

Autonomy, consumerism and risk disclosure should mesh with professional codes and social expectations across institutions and jurisdictions. The medical expert fills a necessary role providing information and helping the patient weigh options and understand the implications. While the provider has the skillset, training and practice to appropriately offer care, the patient will be living with any decisions and the consequences. Fortunately, family medicine providers can support clinical visits with regular queries to the patient that create a safe space for the clinician-patient relationship to be mutually beneficial. Using the concepts of shared decision making along a spectrum of consent, each clinic visit becomes an opportunity to explore. Clinicians should rely on their patient's preferences for management plans, and shared decisions can also expand to include the tone and choreography of the visit itself. The nuanced balance of sharing decisions that adhere to clinical guidelines, patient preferences and medico-legal best practices is an art that only improves with practice.

Endnotes

1. Tunzi, Marc, David J. Satin, and Philip G. Day. "The consent continuum: a new model of consent, assent, and nondissent for primary care." *Hastings Center Report* 51, no. 2 (2021): 33-40.
2. Engelsma, Coos. "Sharing a medical decision." *Medicine, Health Care and Philosophy* 27, no. 1 (2024): 3-14.
3. Engelsma, Coos. "Sharing a medical decision." *Medicine, Health Care and Philosophy* 27, no. 1 (2024): 3-14.
4. Muscat, Danielle M., Heather L. Shepherd, Don Nutbeam, Lyndal Trevena, and Kirsten J. McCaffery. "Health literacy and shared decision-making: exploring the relationship to enable meaningful patient engagement in healthcare." *Journal of general internal medicine* 36, no. 2 (2021): 521-524.
5. Engelsma, Coos. "Sharing a medical decision." *Medicine, Health Care and Philosophy* 27, no. 1 (2024): 3-14.
6. Arvind, T. T., and Aisling M. McMahon. "Responsiveness and the role of rights in medical law: lessons from Montgomery." *Medical law review* 28, no. 3 (2020): 445-477.

__Lisa Morrow, NP, LAc__ is a nurse practitioner in occupational health in an urban teaching hospital and practices telemedicine urgent care and primary care nationally.

__Robert Morrow, MD__ is a retired family physician who continues to contribute to the community through teaching and writing with a particular focus on air quality measurements and healthcare outcomes. He is also Medical Director for Health People, training community leaders who are diabetes health management teachers.

---

continued from page 30

of Training/Preparedness," suggesting the training effectively addressed a critical need for education and confidence. However, "Non-Clinical Support" roles consistently demonstrate a slightly higher proportion of "Disagree" or "Neutral" responses post-intervention across all areas, indicating they might benefit from further tailored support or training to fully align with the positive shifts observed in other clinical and support groups.

Limitations

The limitations of this training include having enough staffing available to train individual offices as the volume of sites is large. As the program progressed, we identified additional staff willing to go through system simulation and effective debriefing prior to training. Unfortunately, access to that training platform was not readily available. We also encountered difficulty in scheduling the site visits as they are done during normal patient care hours. With a large volume of patients, it is often difficult to block time out for training. While we currently are unclear how often sites should be retrained, we recommend a once-yearly training course which is beneficial to help our teams retain the core principles of the program. We also have recommended that any new staff member be given an orientation to this program so they can be an effective team member during a clinical emergency.

Conclusion

Patient safety is a priority in all locations of our health system. While our offices are not intended to see patients with medical emergencies, we do want to have an efficient, safe, and organized response when a patient becomes unstable and needs to be moved to a higher level of care. Our ambulatory offices are often staffed with a mixture of licensed and unlicensed individuals who do not often see emergency situations. Training protocols can minimize stress and facilitate an organized and optimal response.

By the end of training, our goal is to have participants able to identify policies, documentation, procedures, and components of role-based team training related to ambulatory readiness for clinical emergencies. We aim to effectively utilize simulation training and debriefing related to clinical emergencies to achieve team member preparedness. Whether training is needed for a solo practice or on a larger scale, this program may be effectively utilized.

Data collection is promising, revealing the benefit of implementing an ambulatory emergency training program in the quality of care we provide to patients, increasing staff engagement, as well as confidence in handling emergency situations.

__Elaine Schaefer, DO__ is a practicing family medicine physician with Northwell Health since 2010. She has leadership experience with both the Medicine and Family Medicine Service Lines as Associate Medical Director and Physician Executive respectively.

__Nancy Beran, MD, MHCDS__ is the Vice President and Chief Quality Officer for Ambulatory, at Northwell Health where she oversees regulatory requirements for the outpatient network, standardization of workflows, and population health initiatives systemwide implemented at the site level.

__Lora Giacomoni, RN, MSN__, currently serves as the Vice President for Quality & Performance Improvement for Northwell Health's large ambulatory footprint.

__Arvin Maala, RN__ is Assistant Vice President of Clinical Quality Management and Performance Improvement at Northwell Health.

__Angela Cressman, RN__ is the Nurse Manager for Eastern Region Ambulatory at Northwell Health.

Enhancing Patient Experience with
Continuity of Care and Agile Technology

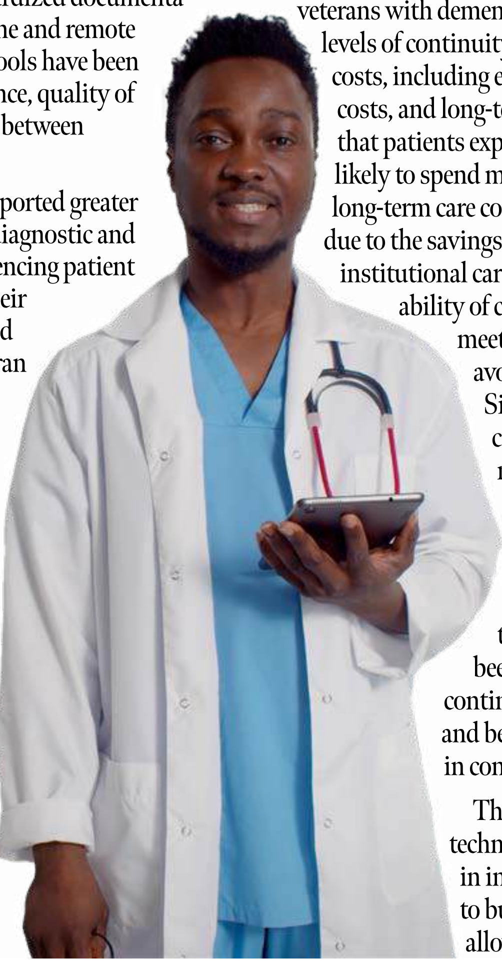
By Mary Rose Puthiyamadam, MD; Linda Qian, MD; Samantha Rai, MD and Harley Roberts, MD

Medicine is undergoing dramatic change, facing threats to funding and the influence of profit-driven interests. At the heart of all of this are patients who seek care that addresses both their emotional and physical needs throughout their healthcare journey. Family medicine is uniquely positioned to play a significant role in improving patient experience, enhancing adherence, elevating clinical quality, and increasing provider satisfaction. Two methods of improving patient experience are continuity of care and evolving technology.

Continuity of care is a cornerstone of improving patient experience, enhancing clinical quality, and ensuring timely access to care. Clinicians familiarize themselves with their patients on a deeper level and can provide personalized and informed management. Trust is established; adherence improves. Physicians are more receptive to registry reports and quality metrics when they relate to their own patients. As these relationships deepen, healthcare outcomes improve. As the saying goes, *"No one cares how much you know until they know how much you care."*

The challenge of our time is to leverage technology to enhance – not detract from – patient care. Physicians increasingly report that they spend more time interacting with computers than with patients during visits, leaving many patients feeling unseen and unheard. In our experience, tools such as ambient AI, standardized documentation, QR codes for patient education, telemedicine and remote patient monitoring, and point-of-care research tools have been instrumental in improving both patient experience, quality of care and engagement in shared decision-making between patients and physicians.

Patients who experienced continuity of care reported greater trust in their physician and confidence in their diagnostic and treatment plan.[1] Physicians reported that experiencing patient continuity provides a better understanding of their patients' values and goals. Fan et al. that observed seven family practice resident clinics in the Veteran Affairs (VA) system found similar correlations between continuity and satisfaction. Their study found that patients who experienced continuity of care reported higher levels of satisfaction with communication and humanistic skills.[2] Continuity with a patient enables the physician and patient to work together toward shared goals, leaving both parties feeling more satisfied with their patient-physician relationship. Physicians also greatly benefit from delivering continuity of care. Those providing continuity of care overwhelmingly report higher levels of confidence in their own diagnosis and management plans, joy and satisfaction in their relationships and overall work, and are invigorated by their complex and challenging cases.



For family medicine physicians, the ability to form these long-standing relationships is often tied to understanding their role as clinicians. Several studies found that family medicine physicians perceived continuity of care as a fundamental part of their identity as family practitioners.[1]

Patient outcomes improve when continuity of care is utilized. One of the most studied metrics in utilization of care is measured by the number of emergency department (ED) visits or hospitalizations. A large cross-sectional analysis of adult Medicaid enrollees found that patients with continuity of care for their chronic conditions were 28% less likely to have an ED visit and 68% less likely to have a hospitalization compared to those without continuity of care.[3] Other studies have found similar correlations in reductions in hospitalizations and emergency department visits with higher continuity of care.[4,5] In a patient-reported qualitative metric of treatment adherence, Nowak et al. found that high levels of continuity of care were correlated with patients reporting higher adherence to treatment plans.[1]

Continuity of care is associated with lower healthcare costs for patients, particularly lowering rates of unnecessary utilization of hospital and emergency services. One study of community-dwelling veterans with dementia found that those who experienced high levels of continuity of care experienced lower total healthcare costs, including emergency department costs, acute inpatient costs, and long-term nursing costs. The same study found that patients experiencing higher continuity of care were more likely to spend more on non-institutional medical and social long-term care costs, but still had lower total care costs, likely due to the savings of home-based long-term care versus institutional care.[6] This is also likely to be driven by the ability of continuity providers to help patients better meet their goals by staying in their homes and avoiding more costly institutionalized care. Similar findings of greater continuity of care correlating with lower total medical costs, mostly due to lower utilization of inpatient or emergency care, have been found in other studies involving different patient populations.[7,8] Remote patient monitoring and telemedicine have become highly valued technology to continuity of care. They have been associated with improved relations, continuous sense of security, fewer readmissions, and better support demonstrating technology's role in continuity and patient experience.[9]

The other enhancement to patient experience is technology. Ambient AI has been transformative in improving patient experience. It has been able to build and deepen relationships with patients, allowing more face-to-face time with the patients

continued on page 35

continued from page 34

rather than facing a computer, enabling improved continuity of care. In 2024, a serial cross-sectional survey was published on over 10,000 family medicine physicians which showed that family medicine has the greatest electronic medical record (EMR) burden among specialties with an average of 6 hours daily spent on documentation, consisting of nearly half of each workday.[10] Implementation of AI documentation assistants has demonstrated significant reductions in provider documentation time and subsequently cognitive load. A multicenter study found that with AI integration the average amount of time per note decreased from 6.2 to 5.3 minutes ($P < .001$), and standardized scores for mental demand, hurried pace, and effort all dropped by more than 5 points ($P < .001$). There were also benefits to physician quality of life with 85.8% of primary care clinicians reporting improved work satisfaction after ambient AI implementation.[11] Clinicians from 30 specialties surveyed on their perspective on AI found that most clinicians believed that AI tools improved their clinic experience, efficiency and job satisfaction, with a significant association with completing clinic notes and decreased burden of documentation.[12] In a study of clinician experiences using AI assistance in the outpatient setting, it was found that ambient scribing tools led to greater clinician efficiency, higher engagement with patients, and lower mental burden.[13] This study noted that clinicians found AI useful in areas, such as recalling details from the clinician encounter and ease of documentation.

When integrated in a relevant and streamlined manner, standardization of documentation embedded in EMRs has also contributed to safer, more efficient evidence-based care. Recent evidence of benefits includes earlier intervention and reduced mortality in sepsis and heart failure, lower hospitalization rates in diabetics, and decreased unplanned cesarean deliveries. In a systematic review and meta-analysis conducted in 2024 of 116 randomized control trials, it was found that using EMR interventions was associated with less risk of 30- and 90-day readmission rates. This results in benefits including lower mortality rates and reduced hospital readmission costs, leading to a decreased burden on our healthcare system.[14]

By focusing on meaningful patient relationships and maintaining a clear, practical vision for our role in healthcare, family physicians can implement solutions that are both patient-centered and outcome-driven.

Endnotes

1. Nowak DA, Sheikhan NY, Naidu SC, Kuluski K, Upshur REG. Why does continuity of care with family doctors matter? Review and qualitative synthesis of patient and physician perspectives. *Can Fam Physician*. 2021;67(9):679-688. doi:10.46747/cfp.6709679. PMID: 34521712; PMCID: PMC9683367.
2. Fan VS, Burman M, McDonell MB, Fihn SD. Continuity of care and other determinants of patient satisfaction with primary care. *J Gen Intern Med*. 2005;20(3):226-33. doi:10.1111/j.1525-1497.2005.40135.x. PMID: 15836525; PMCID: PMC1490082.
3. Gaglioti AH, Li C, Baltrus PT, et al. Interpersonal primary care continuity for chronic conditions is associated with fewer hospitalizations and emergency department visits among Medicaid enrollees. *J Am Board Fam Med*. 2023;36(2):303-312. doi:10.3122/jabfm.2023.020345.
4. Nyweide DJ, Anthony DL, Bynum JP, et al. Continuity of care and the risk of preventable hospitalization in older adults. JAMA Intern Med. 2013;173(20):1879-1885. doi:10.1001/jamainternmed.2013.10059
5. Brousseau DC, Meurer JR, Isenberg ML, Kuhn EM, Gorelick MH. Association between infant continuity of care and pediatric emergency department utilization. Pediatrics. 2004;113(4):738-741. doi:10.1542/peds.113.4.738
6. Lei L, Intrator O, Conwell Y, Fortinsky RH, Cai S. Continuity of care and health care cost among community-dwelling older adult veterans living with dementia. Health Serv Res. 2021 Jun;56(3):378-388. doi: 10.1111/1475-6773.13541.
7. Hussey PS, Schneider EC, Rudin RS, Fox DS, Lai J, Pollack CE. Continuity and the costs of care for chronic disease. JAMA Intern Med. 2014;174(5):742-748. doi:10.1001/jamainternmed.2014.245
8. Romaire MA, Haber SG, Wensky SG, McCall N. Primary care and specialty providers: an assessment of continuity of care, utilization, and expenditures. Medical Care. 2014;52(12):1042-1049. doi:10.1097/MLR.0000000000000246
9. Rhoden PA, Bonilha H, Harvey J. Patient Satisfaction of Telemedicine Remote Patient Monitoring: A Systematic Review. Telemed J E Health. 2022 Sep;28(9):1332-1341. doi: 10.1089/tmj.2021.0434. Epub 2022 Jan 17. PMID: 35041549.
10. Rotenstein LS, Hendrix N, Phillips RL, Adler-Milstein J. Team and Electronic Health Record Features and Burnout Among Family Physicians. JAMA Netw Open. 2024 Nov 4;7(11):e2442687. doi: 10.1001/jamanetworkopen.2024.42687. PMID: 39499518; PMCID: PMC11539011.
11. Stults CD, Deng S, Martinez MC, Wilcox J, Szwerinski N, Chen KH, Driscoll S, Washburn J, Jones VG. Evaluation of an Ambient Artificial Intelligence Documentation Platform for Clinicians. JAMA Netw Open. 2025 May 1;8(5):e258614. doi: 10.1001/jamanetworkopen.2025.8614. PMID: 40314951; PMCID: PMC12048851.
12. Albrecht M, Roberts D, Wilcock J. Enhancing clinical documentation with ambient artificial intelligence: a quality improvement survey assessing clinician perspectives on work burden, burnout, and job satisfaction. *JAMIA Open*.2025;8(1):ooaf013. doi:10.1093/jamiaopen/ooaf013.
13. Duggan MJ, Weiss CL, Olson KD, Fischer HA, Shah KP. Clinician experiences with ambient scribe technology to assist with documentation burden and efficiency. *JAMA Netw Open*.2025;8(3):e2830383. doi:10.1001/jamanetworkopen.2025.2830383.
14. Pattar BSB, Ackroyd A, Sevinc E, Hecker T, Turino Miranda K, McClurg C, Weekes K, James MT, Pannu N, Ravani P, Ronksley PE, Ahmed SB, Harrison TG. Electronic health record interventions to reduce risk of hospital readmissions: a systematic review and meta-analysis. *JAMA Netw Open*.2025;8(7):e2521785. doi:10.1001/jamanetworkopen.2025.21785. PMID: 40674049; PMCID: PMC12272288.

***Mary Rose Puthiyamadam, MD** is part of the Phelps Family Residency at Northwell and Medical Director of Clinical Quality. She has relished continuity of care for more than 20 years and uses technology in various ways to enhance patient care.*

***Linda Qian, MD** is a second year family medicine resident at the Zucker School of Medicine at Hofstra/Northwell at Phelps. She is interested in the use of technology to improve patient care in efficient and comprehensive ways.*

***Samantha Rai, MD** is the Medical Director at the Open Door Family Medical Centers, Sleepy Hollow site and is an Associate Program Director at the Phelps/Northwell Family Medicine Residency Program.*

***Harley Roberts, MD** is a second year family medicine resident at the Zucker School of Medicine at Hofstra/Northwell at Phelps Hospital. She is passionate about the power of continuity of care to empower patients in their healthcare journey and help physicians best meet their patients' needs.*

Where's Amy?: A Look Into the Physician – Pharmacist Co-Visit Model

By Jennifer Maguire, MD and Amy Thein, PharmD

Jennifer Maguire, MD: *My Epic in-basket looks like the whack-a-mole game at an amusement park… wait, I just cleared it out five minutes ago and new high-priority items are already popping up? I review my schedule for the morning session: sibling well child visits, Medicare Wellness Visit, adult physical, hospital follow-up, acute abdominal pain, chronic pain follow-up, husband and wife (Mr. and Mrs. Benson*) coming in for chronic disease management, and others. I see an eager medical student who I am scheduled to work with for the day. While excited about the variety in patient presentations, I am starting to get nervous about how to efficiently navigate the busy patient care session this is shaping up to be without letting patients see the controlled chaos behind the scenes. Then, I see next to the Mr. and Mrs. Benson's reason for visit: "Co-visit with clinical pharmacist." I suddenly feel a wave of relief.*

I enter the exam room with Mr. and Mrs. Benson, a "few" minutes late. Amy, the clinical pharmacist, is already busy at work reviewing Mrs. Benson's glucometer data, Mr. Benson's inhaler administration technique, reconciling both of their extensive and complex medication lists, preparing refills and making dose adjustments based on blood pressure and blood sugar control. Do I see a monofilament out for Mrs. Benson's diabetic foot exam? Is that the vaccine information sheet on the desk showing they already received their flu shots? The group welcomes me to the visit – wait, aren't I supposed to be the one welcoming them? I can feel the positive energy in the room and join the conversation. I complete my role in the visit; updating their interval progress, complete a focused exam, and review the plan. Mr. Benson's blood pressure is above goal – we adjusted one of his medications; Mrs. Benson's blood sugars have been higher in the setting of dietary challenges - we adjust her GLP-1. Done. Back on time, or closer to.

The pair sees Amy via a video visit 2 weeks later. Mr. Benson's home blood pressure readings are better. Mrs. Benson requests a continuous glucose monitor (CGM) to better track some of her low glucose readings. Can we order one? Amy orders CGM sensors and a receiver and makes a plan for training in 2 weeks at Mrs. Benson's next co-visit. No surprise, a prior authorization is needed. Thankfully, Amy coordinates this with our medication access specialist and communicates this to the patient.

We plan another co-visit in the office 2 weeks later. Amy configures and applies the CGM as I and the medical student observe and learn this new technical skill. We scheduled a follow-up visit in another month. At that next visit, I enter the room first while Amy is finishing up with another patient. The Bensons ask – ***"Where's Amy?"***

Our practice is a large, urban, academic, safety net family medicine practice in Rochester, NY. It is composed of nearly 80 clinicians in one building, including residents (physician, nurse practitioner), fellows (sports medicine, maternal child health), nurse practitioners (NPs), and faculty physicians. We have approximately 26,000 patients under our care with a large proportion covered by Medicaid and who identify as a racial or ethnic minority.

Clinical pharmacy services have long been a staple in the team-based model in primary care.[1] The role of a clinical pharmacist has evolved from a consultative chart review into a more direct and active role with physicians. The pharmacist-physician "co-visit" is one way we collaborate to bring quality and equitable care to our patients. The co-visit is a pre-scheduled appointment with the patient, clinical pharmacist, and family physician or nurse practitioner. Patients have time to ask medication questions and engage in real-time shared decision-making with their care team. Approximately 2-4 weeks later, a scheduled clinical pharmacist visit allows for continuity and close follow-up on chronic issues addressed.

This patient care narrative above represents only one of the many overwhelmingly positive experiences I have had as a physician working with the clinical pharmacist. In my role as quality director for our office, I care about the many facets that go into providing quality care to patients. The IHI (Institute for Healthcare Improvement) Quintuple

continued on page 37

continued from page 36

Aim coherently describes these aspects: improving care, improving population health, advancing health equity, improving workforce well-being, and lowering cost.[2] Working with Amy on the care of these two patients allowed many of these goals to be achieved: improving individual diabetes and blood pressure control through medications and device recommendations, providing equitable care to patients with chronic mental health and low socioeconomic status, reducing risk and cost of re-admission to hospital for complications of hypertension and diabetes, and more joy in the team based approach to benefit our care team (Figure 1).

Figure 1:
The co-visit model, described in the narrative above, is a unique collaboration between a clinician and clinical pharmacist that allows for a patient-centered approach to care. This model offers several pragmatic benefits to the patient:

- A single office visit to meet with both the clinician and clinical pharmacist in a familiar primary care environment
- Ability to use time efficiently depending on the available resource
- Dynamic decision-making and coordination of plan for close follow-up
- Medical device education and application
- Connection to medication access services
- Expanding the clinical team to support access and continuity of care

Amy Thein, PharmD: *Embedding a full-time clinical pharmacist in a primary care setting was a relatively novel idea for our health system when I began at the clinic 6 years ago, and I was both thrilled and intimidated by such a challenge. The practice is large - the physical space is immense, and the number of clinicians can feel overwhelming. I first pitched the idea of a co-visit to a physician that had worked with clinical pharmacists in prior roles. I piloted this as a way to see more patients without taking up additional physical clinic space. I initially focused on offering tips and tricks for patients with difficult to control diabetes and provided medication optimization suggestions to help reduce pill burden from unintended polypharmacy. Over time, I gradually established my own clinic schedule, helping patients in a multitude of ways, including co-management of chronic disease and improving medication access, while being available for on-the-fly questions. I continue to prioritize co-visits in my workday, as this model reinforces the value of team-based, patient-centered care. Over time, I am proud to say that I have had co-visits with the majority of our clinicians – some early adopters, while others have taken some time to foster the collaboration. Learning the range of work styles of nearly 80 clinicians has been more of a learning curve than managing some of the comorbidities of our complex patients!*

Utilization of a clinical pharmacist with the skills to employ a comprehensive medication management (CMM) model of care seemed like a natural fit for our family medicine residency program.[3] Family physician training emphasizes collaboration across disciplines. In our practice, interdisciplinary colleagues include nurse practitioners, behavioral health specialists, community health nurses, outreach workers with a focus on lactation, and others. While a residency practice with a strong culture of collaboration made embedding a full-time clinical pharmacist a logical next step, any family practice that embraces team-based care can appreciate this resource. Clinical pharmacists have a unique knowledge base and skill set that can complement the family physician's role, while also improving both patient satisfaction and patient outcomes.

The CMM model of care centers on ensuring each medication for the patient is indicated, effective, safe, and accessible as prescribed. CMM allows the clinical pharmacist to optimize medications, in conjunction and collaboration with the health care team, to help the patient achieve therapeutic goals of care.[3,4] The clinical pharmacist is integral in providing follow-up on the agreed upon medication regimen to ensure it continues to fit the patient's needs. One important tool for providing the most robust CMM model of care is the use of a Collaborative Drug Therapy Agreement (CDTM).[5] This is a signed agreement between the physician, pharmacist and patient that allows the clinical pharmacist to adjust doses of medications and add lab orders within pre-specified disease states and classes of medications. This can be executed in pharmacist–physician co-visits to enable coordinated medication decision-making.

Numerous articles have been published highlighting the outcomes of CMM.[4] Pharmacists performing CMM can help reduce overall healthcare costs by using close collaboration to improve health outcomes in chronic conditions such as hypertension and diabetes, while also reducing hospital and ED visits.[4] In addition to better outcomes and lower costs, pharmacists who work closely with members of the healthcare team improve health equity and both patient and clinician experience.[6,7] Published evidence highlights the use of a co-visit model to improve access to pharmacy services, and also indicates co-visits can expand opportunities for meaningful collaboration with primary care team members.[8,9]

Jennifer Maguire, MD & Amy Thein, PharmD: Together, we feel the co-visit model offers a unique opportunity to improve the patient experience by providing increased access and collaboration. We are interested in expanding this model to include more clinicians, particularly more medical residents, and further expanding the scope of the clinical pharmacist role in our value-based care programs. We are confident that this close collaboration has the potential to expand to other practice settings, including rural and suburban locations, as we have seen within our healthcare network (Figure 2). We encourage you to find your Amy - be a champion for collaboration and embrace the co-visit.

Figure 2:
If you are interested in embedding a clinical pharmacist in your practice, here are a few suggestions for how to get started:

- Consider partnership with local school of pharmacy or pharmacy residency programs
- Connect with medical residency programs on how to add pharmacist as a faculty member
- Empower a physician champion, who can model the partnership with the pharmacist
- Facilitate repeated exposure of the pharmacist to the clinicians through on-site presence (I e. workspace near exam rooms or physician office space)
- Foster a culture of collaboration driven by mutual respect and understanding

*names changed for privacy

continued on page 43

Emoji-Based Patient Feedback:
Response Rates and Feedback of Emoji-Driven Patient Questionnaires

By Matthew Heffernan, DhIc; Nicole Mendez; William Heffernan, MD and Rahal Mittal, MD

Introduction

Measuring patient experience is central to high-quality, patient-centred healthcare. Accurate and timely feedback helps clinicians understand how individuals perceive their care, identify communication challenges, and evaluate the emotional dimensions of treatment interactions. Despite its importance, patient feedback remains one of the least optimized components of healthcare evaluation. Traditional mechanisms, such as mailed satisfaction surveys, telephone interviews, and written questionnaires, frequently yield low response rates, limiting emotional insight, particularly among individuals with cognitive, linguistic, or literacy challenges.

Nonverbal communication plays a significant role in clinical encounters, influencing patient perceptions of empathy, trust, and interpersonal rapport, finding that nonverbal cues, including eye contact, posture, and facial expressions, shape patients' evaluations of clinician empathy and quality of care.[1] Yet these subtle interpersonal elements are rarely captured through conventional survey instruments.

In parallel, communication norms have evolved, particularly with the widespread adoption of smartphones and digital messaging. Emojis have become a central symbolic component of everyday communication, functioning as visual analogues to nonverbal cues. Research suggests that emojis enhance emotional expressiveness, reduce ambiguity in digital communication, and support individuals with varying literacy levels. Their growing presence in healthcare communication, including among clinicians themselves, signals broader acceptance of symbolic visual language in professional contexts.

The need for accessible and emotionally sensitive feedback tools is especially pronounced in social prescribing, a care model that connects individuals to community-based, non-medical forms of support. Social prescribing relies heavily on patients' subjective experiences, including emotional well-being, confidence, social connectedness, and perceived support. Yet evaluation strategies in social prescribing have not kept pace with service expansion. Many programs report limited feedback, poor survey engagement, and difficulty capturing emotional outcomes central to the model. To address these limitations, a digital emoji-based feedback tool was developed and piloted within two social prescribing services in Cornwall. This study evaluates the feasibility, usability, and value of this visual, emotion-cantered digital feedback system and examines its ability to capture meaningful insights into patient experience.

Literature Review

Patient feedback is essential to understanding patient satisfaction, quality care, and clinician empathy in healthcare settings. Historically, feedback mechanisms have relied primarily on verbal and written communication. However, emerging research highlights the importance of nonverbal cues and symbolic communication, particularly, as digital communication has become embedded in clinical practice. As healthcare increasingly adopts digital tools, visual and symbolic elements such as emojis have emerged as meaningful extensions of nonverbal communication, giving patients new ways to express emotion and evaluate their care experiences.[2]

Traditional patient feedback methods such as post-visit surveys, structured questionnaires, and interviews, have long served as the primary means of eliciting patient perspectives. These tools provide

continued on page 39

Figure 1: Interface Design of Survey Instrument

How helpful has the Service been to you?

continued from page 38

useful aggregate data but often fail to capture the nuanced interpersonal dynamics of clinical encounters.[3] However, because traditional surveys rely on retrospective reporting, they regularly miss the moment-to-moment nonverbal cues that shape patient experiences. Additionally, conventional written surveys pose accessibility barriers; with more than half of U.S. adults reading below a sixth-grade level,[4] many patients struggle with text-heavy feedback forms. Consequently, traditional tools often produce low response rates, limited detail, and restricted representation of marginalized or low-literacy groups.[5]

In response to these limitations, healthcare organizations increasingly adopt real-time, digital feedback mechanisms such as patient portals, automated text messages, and mobile-based surveys.[1] These systems allow patients to describe their experiences immediately after an encounter, improving sensitivity to specific behaviours and emotional moments. Real-time feedback also enables clinicians and healthcare teams to adjust communication practices more rapidly, increasing the timeliness and relevance of patient-reported data.[2]

At the same time, symbolic communication, particularly through emojis—has become a meaningful component of patient–clinician interaction. He, Lee, and Davis emphasize that emojis act as a visual language capable of conveying emotional nuance that text alone may not capture, particularly for individuals with language or literacy barriers.[2] As modern communication increasingly relies on pictographic symbols, clinicians are recognizing the potential of emoji-based tools to reduce patient burden, simplify communication, and enhance emotional expressiveness.[7] Emojis can serve as intuitive equivalents for nonverbal cues such as tone of voice or facial expression, allowing patients to share affective states more naturally.

Recent research also reveals that emojis are not used exclusively by patients. In a 2023 JAMA Network Open analysis of over 1,300 clinical text message threads, Halverson et al. found that clinicians frequently used emojis to communicate with colleagues.[2] The majority of emojis served emotive or relational functions, such as signalling encouragement, softening requests, or maintaining connection, without compromising professionalism or clarity. These findings suggest that emojis are already embedded in clinical communication norms, further supporting their integration into patient-facing feedback systems. Evidence from patient-centred research also demonstrates the potential of emoji-driven feedback tools.

Despite these promising developments, challenges remain. Emojis vary across cultures, devices, and age groups, and their meanings may not be universally shared. Studies show that the same emoji can be interpreted differently depending on context, linguistic background, or platform rendering.[6] Emoji-only feedback may also lack specificity, limiting clinicians' ability to distinguish mild dissatisfaction from serious concern. As a result, researchers argue for the creation of validated, standardized emoji-based scales tailored to healthcare environments. While there isn't yet a single study that combines text and emojis with wearable sensors and artificial intelligence to detect nonverbal cues, research supports each component independently. Emojis, for instance, can improve patient-clinician communication,[2] and wearable sensors combined with artificial intelligence (AI) allow for the real-time recording of nonverbal cues.[8] Thus, a hybrid system that combines the two is a reasonable next step.

Overall, the evolution of patient feedback has progressed from broad, text-based surveys to more immediate, accessible, and symbol-rich digital platforms. Incorporating emoji-based communication represents a natural extension of patient-centred care: it enhances accessibility, captures emotional nuance, and supports cross-cultural communication.[3] As healthcare systems continue to integrate digital tools and prioritize empathy-driven care, feedback mechanisms that embrace both symbolic and nonverbal dimensions may offer deeper insights into patient experiences and strengthen the clinician–patient relationship.

Social Prescribing and the Need for Accessible Feedback

Social prescribing (SP) connects individuals to non-medical community resources, such as wellbeing activities, support groups, exercise programs, and social services. Its goal is to enhance holistic wellbeing, reduce loneliness, and empower individuals to engage actively in their communities. Because SP focuses on relational and emotional outcomes, effective evaluation requires capturing how supported, connected, and understood individuals feel.

Yet SP services often lack consistent evaluation methods. In Cornwall, existing feedback tools produced low return rates and inconsistent data, reflecting national trends. The Cornwall evaluation explicitly noted "poor returns and mixed success" from traditional SP questionnaires.

To address these barriers, St. Austell Healthcare and Community Connect partnered with Umbrella Insight to co-develop an emoji-based, web-delivered feedback tool. The platform was intentionally designed to be fast, simple, and accessible on any device. It advanced automatically after each response, minimizing burden. Emojis were incorporated to capture emotional states central to SP outcomes—wellbeing, connection, trust, and satisfaction. Given this, this study aimed to evaluate this new feedback approach by assessing the engagement and satisfaction rates received from patients.

Methods

Design

A mixed-methods evaluation design was used, combining quantitative engagement metrics with qualitative thematic analysis of patient comments using a web-based feedback tool to garner patient experience using their social prescribing services.

Setting

For development of the tool, two social prescribing services in the United Kingdom at Cornwall, St. Austell Healthcare and Community Connect, Truro, participated in this pilot over the course of a 6-month period. These services participated due to the lack of evaluation services available to them and due to the differences in their approach and delivery of social prescribing and patient demographics.

continued on page 40

continued from page 39

Participants

Participants included patients who had recently completed or exited the social prescribing service. All participants were invited to provide feedback through a web-based link. Participation was voluntary and anonymous.

Co-Production and Development Process

The questionnaire was co-produced through an iterative design process involving link workers, and staff from both social prescribing sites, as well as patient focus groups used to gather patient perspectives on question clarity, test ease of use of emoji formatting, identify meaningful emotional indicators, ensure accessibility across literacy level and age groups, and evaluate the overall interface and ease of use of the tool itself. This feedback was integrated into the final wording, flow and final emoji selection for the tool to better reflect the patient population's lived experiences and communication preferences. Interface was designed as per Figure 1 to demonstrate the appearance of the tool.

Instrument

The feedback instrument was a web-based digital questionnaire and was developed and designed by Umbrella Insight for social prescribing, featuring questions that would measure multiple dimensions of patient wellbeing utilizing emojis, such as emotional wellbeing, physical health and connectedness, satisfaction and likelihood of recommending services, or feeling the patient was listened to and understood. Additional demographic items, such as age group and gender, were also collected for further analysis. Additionally, an open-text comment box was added to elicit qualitative feedback or suggestions in addition to the quantitative feedback being elicited by the emoji-driven questions.

Procedure

Patients received the survey via SMS or email. No login or app download was required. The platform automatically advanced after each response, minimizing respondent burden and supporting accessibility. Deidentified responses from patients were then stored in a secure cloud storage facility through Umbrella Insight. Data was then retrieved through a shared dashboard for final data analysis.

Data Analysis

Quantitative data, including messages sent, response rates, emoji-based scorings, and usability ratings, were stored within the Umbrella Insight databases and were exported using the Umbrella Insight dashboard. Microsoft Excel was then utilized to perform evaluation of the exported data. Demographics and patient satisfaction rates were calculated using Microsoft Excel. For patient satisfaction rates, emoji responses were assigned a value between 1 and 5, with 1 corresponding to "Very Unhappy" and 5 corresponding to "Very Happy". Using this, a mean satisfaction score was calculated by multiplying the emoji response value by the number of respondents in each category and dividing by the total number of respondents. An independent T-test was performed to assess for statistically significant differences between the responses of the patients responding to the questionnaire using Python with the SciPy library.

Additionally, qualitative comments were reviewed and analyzed using thematic content analysis to identify common patterns to wellbeing, support, and service experience.

Results

Response Rates and Participant Characteristics

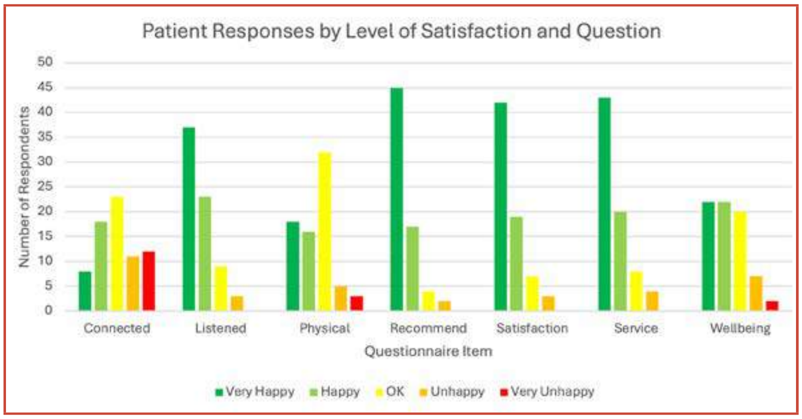
40 clients from Community Connect and 60 clients from St. Austell were sent the questionnaire, with a total of 73 patients responding to the questionnaire, resulting in an 82% response rate from Community Connect and a 66% response rate from St. Austell. Respondents were more likely to be female than male at both Community Connect (58% female vs 42% male) and St. Austell sites (60% female vs 40% male). Of the respondents 60.3% of patients being in an age bracket over the age of 55, while 39.7% of respondents were 54 or younger. Patient age breakdown provided as per Table 1 and Figure 2.

Additionally, respondents predominantly preferred communication via phone (n = 22/38, 57.8%) with other options such as face-to-face (n = 10/38, 26.3%), email (n = 3/38, 7.9%) and text (n = 3/38, 7.8%) being less preferred.

Table 1: Respondent Demographics

Age Bracket	**Community Connect** (Male/Female, % Male)	**St. Austell** (Male/Female, % Male)	**Total** (Male/Female, % Male)
Under 25	2/2 (6.1%)	1/3 (2.5%)	3/5 (4.1%)
25-34	0/0 (0%)	4/0 (10%)	4/0 (5.5%)
35-44	0/2 (0%)	4/3 (10%)	4/5 (5.5%)
45-54	1/1 (3%)	2/4 (5%)	3/5 (4.1%)
55-64	2/2 (6.1%)	1/8 (2.5%)	3/10 (4.1%)
65-74	1/3 (3%)	1/3 (2.5%)	2/6 (2.7%)
75+	8/9 (24.2%)	2/4 (5%)	10/13 (13.7%)
Total	14/19 (42.4%)	15/25 (37.5%)	29/44 (39.7%)

Figure 2: Patient Responses by Level of Satisfaction and Question



continued on page 41

continued from page 40

Quantitative Feedback

Overall questionnaire responses provided as per Table 2. Patients reported overall feeling happy with their experience (mean = 4.0), with the St. Austell site reporting slightly higher satisfaction rates (mean = 4.1) as compared to Community Connect (mean = 3.9). All sites reported high satisfaction (mean = 4.4), service (mean = 4.4), and feeling listened to rates (mean = 4.3), with patients reporting a high rate of likelihood to recommend to others (mean = 4.5). There existed no statistically significant difference between the responses of the St. Austell and Community Connect patient responses. (p = 0.5342)

Qualitative Themes

Open-text comments provided context for the emoji ratings and revealed three primary themes:

1. **Feeling Heard, Supported, and Less Alone**
   Patients frequently described emotional and relational benefits from regular contact with staff. Comments emphasized being "listened to," "understood," and "not judged," often linking emotional support to improved confidence and wellbeing.
2. **Practical Help and Reduced Burden**
   Many respondents highlighted the value of assistance with concrete tasks, such as accessing equipment, coordinating medications, or navigating community services. The sense of "getting things done" and reducing stress contributed to positive ratings.
3. **Suggestions for Continued or Expanded Support**
   Constructive feedback centered on service capacity and continuity rather than dissatisfaction. Some participants requested longer-term support, more face-to-face options post-pandemic, or increased staffing to reach more isolated people. Even suggestions were paired with positive emojis, indicating high overall acceptance of the service.

Discussion

This study evaluated the feasibility and acceptability of an emoji-based feedback tool within social prescribing services in England. While the findings are grounded in a UK context, recent evidence suggests that the underlying principles of social prescribing and patient experience measurement are increasingly relevant beyond the UK, including within the United States. However, generalisation across health systems should be interpreted cautiously given structural, funding, and delivery differences.

Emerging peer-reviewed evidence demonstrates that social prescribing models originating in the UK are already being implemented and evaluated within U.S. healthcare settings. A recent synthesis published in The Lancet Public Health documents the rapid growth of social prescribing initiatives across the United States, including within largely privatized healthcare systems, and highlights shared challenges related

continued on page 42

Table 2: Patient Responses

Question	Very Happy	Happy	OK	Unhappy	Very Unhappy
Connected	8/72 (11.1%)	18/72 (25%)	23/72 (31.9%)	11/72 (15.3%)	12/72 (16.7%)
Listened	37/72 (51.4%)	23/72 (31.9%)	9/72 (12.5%)	3/72 (4.2%)	0/72 (0%)
Physical	18/74 (24.3%)	16/74 (21.6%)	32/74 (43.2%)	5/74 (6.8%)	3/74 (4.1%)
Recommend	45/71 (63.4%)	17/71 (23.9%)	4/71 (5.6%)	2/71 (2.8%)	0/71 (0%)
Satisfaction	42/71 (59.2%)	19/71 (26.8%)	7/71 (9.9%)	3/71 (4.2%)	0/71 (0%)
Service	43/75 (57.3%)	20/75 (26.7%)	8/75 (10.7%)	4/75 (5.3%)	0/75 (0%)
Wellbeing	22/73 (30.1%)	22/73 (30.1%)	20/73 (27.4%)	7/73 (9.6%)	2/73 (2.7%)

Table 2a: Patient Responses (Community Connect)

Question	Very Happy	Happy	OK	Unhappy	Very Unhappy
Connected	2/32 (6.3%)	10/32 (31.3%)	9/32 (28.1%)	4/32 (12.5%)	7/32 (21.9%)
Listened	13/32 (40.6%)	16/32 (50%)	2/32 (6.3%)	1/32 (3.1%)	0/32 (0%)
Physical	1/32 (3.1%)	8/32 (25%)	18/32 (56.3%)	2/32 (6.3%)	3/32 (9.4%)
Recommend	19/32 (59.4%)	10/32 (31.3%)	2/32 (6.3%)	0/32 (0%)	0/32 (0%)
Satisfaction	16/32 (50%)	11/32 (34.4%)	4/32 (12.5%)	1/32 (3.1%)	0/32 (0%)
Service	18/33 (54.5%)	11/33 (33.3%)	1/33 (3%)	3/33 (9.1%)	0/33 (0%)
Wellbeing	6/32 (18.8%)	13/32 (40.6%)	11/32 (34.4%)	1/32 (3.1%)	1/32 (3.1%)

Table 2b: Patient Responses (St. Austell)

Question	Very Happy	Happy	OK	Unhappy	Very Unhappy
Connected	6/40 (15%)	8/40 (20%)	14/40 (35%)	7/40 (17.5%)	5/40 (12.5%)
Listened	24/40 (60%)	7/40 (17.5%)	7/40 (17.5%)	2/40 (5%)	0/40 (0%)
Physical	17/42 (40.5%)	8/42 (19%)	14/42 (33.3%)	3/42 (7.1%)	0/42 (0%)
Recommend	26/39 (66.7%)	7/39 (17.9%)	2/39 (5.1%)	2/39 (5.1%)	0/39 (0%)
Satisfaction	26/39 (66.7%)	8/39 (20.5%)	3/39 (7.7%)	2/39 (5.1%)	0/39 (0%)
Service	25/42 (59.5%)	9/42 (21.4%)	7/42 (16.7%)	1/42 (2.4%)	0/42 (0%)
Wellbeing	16/41 (39%)	9/41 (22%)	9/41 (22%)	6/41 (14.6%)	1/41 (2.4%)

continued from page 41

to patient engagement, equity, and the measurement of wellbeing outcomes.[9] Similarly, the first formal U.S. pilot evaluation of social prescribing demonstrated feasibility, positive stakeholder acceptance, and wellbeing benefits, providing early evidence that UK-origin models can be adapted to U.S. contexts.[10]

In parallel, patient experience measurement is a well-established component of U.S. healthcare quality assessment. National frameworks such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) underscore the central role of patient-reported experience data in accountability and quality monitoring. Methodological research has emphasized the need for feedback tools that balance validity with usability, particularly for quality improvement purposes where low respondent burden and acceptability are critical.[11,12] Industry-scale analyses of more than 10.5 million U.S. patient encounters reinforce this need, highlighting persistent disparities in patient experience and identifying trust, communication, and perceived safety as key drivers of experience across care settings.[13]

These measurement challenges are occurring within a U.S. healthcare system that is increasingly focused on redesigning care delivery to improve value, efficiency, and patient engagement. Editorial leadership from The New England Journal of Medicine has highlighted the growing importance of innovation in care delivery models that prioritize patient engagement, experience, and system-level learning, noting that while health systems differ structurally, patients' core needs and expectations are broadly similar across countries.[14] This emphasis on scalable, transferable innovations provides a relevant conceptual framework for considering the applicability of novel patient-experience tools beyond their original setting.

The emoji-based feedback approach evaluated in this study aligns with these priorities by offering a low-burden, accessible method for capturing emotional and experiential dimensions of care. Such characteristics are particularly relevant in contexts where literacy barriers, survey fatigue, and time constraints limit engagement with traditional text-based questionnaires. This is supported by recent empirical evidence demonstrating that emojis are widely used and generally interpretable across age groups and cultural contexts, although some variation in interpretation exists.[6] Importantly, the use of symbolic or sentiment-based feedback tools is consistent with broader health-system trends toward digitally enabled patient-experience analytics, including the application of natural language processing to free-text survey comments. Recent large-scale analyses of patient experience survey data illustrate how such approaches can identify actionable themes in patient-reported care experiences, providing methodologically relevant insights for CAHPS/HCAHPS-style feedback ecosystems.[15]

In addition to peer-reviewed evidence, practice-level developments and public discourse in the United States further underscore the relevance of low-burden, real-time feedback mechanisms and social prescribing approaches. Healthcare organizations increasingly supplement established survey instruments with point-of-care feedback tools designed to capture patient experience immediately following care encounters, with the aim of improving responsiveness and engagement. Industry reports describing the use of instant, symbol-based feedback systems in healthcare settings highlight perceived advantages such as higher response rates, reduced recall bias, and usability across diverse patient populations, although these reports do not constitute formal evaluations of effectiveness.[16] Similarly, social prescribing has gained growing visibility in U.S. public health and policy discourse, with mainstream scientific commentary reflecting increasing interest among clinicians, patients, and policymakers in prescribing community-based, non-clinical interventions to address social and emotional determinants of health.[17]

Taken together, while the findings of this study cannot be assumed to directly generalize to U.S. healthcare systems, the growing U.S. evidence base for social prescribing, established patient experience infrastructures, documented workforce and system pressures, and increasing emphasis on patient-centred care delivery support cautious transferability. Future research should evaluate emoji-based patient feedback tools directly within U.S. clinical and community-based settings to assess cultural adaptability, implementation feasibility, and impact on service improvement. Nonetheless, the present findings contribute to a broader international discussion on how patient experience—particularly emotional wellbeing—can be captured more inclusively and efficiently across diverse healthcare contexts.

Conclusion

Emoji-based digital questionnaires represent a practical and effective solution to long-standing challenges in patient experience evaluation. Their simplicity, accessibility, and emotional expressiveness make them particularly suitable for social prescribing contexts, where subjective wellbeing and relational support are central. The strong response rates and positive usability findings from this study demonstrate the potential for broader adoption of emoji-enabled tools across healthcare systems globally.

Endnotes

1. Remer, L. M., Line, K., Paolella, A., Rozniak, J. M., & Alessandrini, E. A. (2024a, April 9). Use of daily web-based, real-time feedback to improve patient and family experience. Journal of patient experience. https://pmc.ncbi.nlm.nih.gov/articles/PMC11005486/?utm_source=chatgpt.com
2. He, S., Lee, J., & Davis, K. (2023). Interpreting emoji — A language for enhancing communication in health care. JAMA Network Open, 6(6), e2318073. https://doi.org/10.1001/jamanetworkopen.2023.18073
3. Huh, E. (2025, July 2). The impact of emojis on perceived responsiveness and relationship satisfaction in text messaging. PloS one. https://pmc.ncbi.nlm.nih.gov/articles/PMC12221085/
4. 2024-2025 literacy statistics. National Literacy Institute. (n.d.-b). https://www.thenationalliteracyinstitute.com/2024-2025-literacy-statistics
5. Price M, Legrand AC, Brier ZMF, van Stolk-Cooke K, Peck K, Dodds PS, Danforth CM, Adams ZW. Doomscrolling during COVID-19: The negative association between daily social and traditional media consumption and mental health symptoms during the COVID-19 pandemic. Psychol Trauma. 2022 Nov;14(8):1338-1346. doi: 10.1037/tra0001202. Epub 2022 Feb 14. PMID: 35157484; PMCID: PMC10074257

continued on page 43

continued from page 42

6. Chen, Yihua, Xingchen Yang, Hannah Howman, and Ruth Filik. "Individual Differences in Emoji Comprehension: Gender, Age, and Culture." PLOS ONE 19, no. 2 (February 14, 2024). https://doi.org/10.1371/journal.pone.0297379.
7. He, S. (2023, August 10). The importance of using emoji in healthcare. Massachusetts General Institute of Health Professions. https://www.mghihp.edu/news-and-more/news/importance-using-emoji-healthcare
8. Wang, Tingting, Guido Giunti, Richard Goossens, and Marijke Melles. "Timing, Indicators, and Approaches to Digital Patient Experience Evaluation: Umbrella Systematic Review." *Journal of Medical Internet Research* 26, no. 1 (2024): e46308. doi:10.2196/46308.
9. Marshall, R., Fancourt, D., et al. (2025). Social prescribing in the USA: Emerging learning and opportunities. The Lancet Public Health. Advance online publication. https://doi.org/10.1016/S2468-2667(25)00066-0
10. Golden, T. L., Maier Lokuta, A., Mohanty, A., Tiedemann, A., & Fancourt, D. (2023). Social prescription in the US: A pilot evaluation of Mass Cultural Council's "CultureRx". Frontiers in Public Health, 10, 1016136. https://doi.org/10.3389/fpubh.2022.1016136
11. Beattie, M., Murphy, D. J., Atherton, I., & Lauder, W. (2015). Instruments to measure patient experience of healthcare quality in hospitals: A systematic review. Systematic Reviews, 4, 97. https://doi.org/10.1186/s13643-015-0089-0
12. Al-Abri, R., & Al-Balushi, A. (2014). Patient satisfaction survey as a tool towards quality improvement. Oman Medical Journal, 29(1), 3–7. https://doi.org/10.5001/omj.2014.02
13. Press Ganey. (2025). Patient experience 2025: New data from 10.5 million patient encounters. Press Ganey Associates.
14. Lee, T. H., Mohta, N. S., Prewitt, E., Campion, E. W., Morrissey, S., Drazen, J. M., & Rubin, E. J. (2020). NEJM Catalyst innovations in care delivery — A new journal leading the transformation of health care delivery. New England Journal of Medicine, 382(1), 80–81. https://doi.org/10.1056/NEJMe1914982
15. Steele, B., Fairie, P., Kemp, K., D'Souza, A. G., Wilms, M., & Santana, M. J. (2025). Identifying patient-reported care experiences in free-text survey comments: Topic modeling study. JMIR Medical Informatics, 13, e63466. https://doi.org/10.2196/63466
16. HappyOrNot. (2025). Measuring the patient experience with instant feedback. HappyOrNot Ltd.
17. Hotz, J. (2024). Doctors should offer "social prescribing" to patients. Scientific American.

***Matthew Heffernan, DHIc** is currently a doctoral candidate in health informatics through Rutgers University with 20 years of experience in health information technologies, patient care, and medical research.*

***Nicole Mendez** is a cognitive science student at Rutgers University, with research experience in neuroscience, social prescribing, and international health collaboration.*

***William Heffernan, MD** is a board-certified family physician through Nuvance Health with over 40 years of patient care experience, including being an early advocate of electronic health record integration into the physician's practice of medicine.*

***Rahul Mittal, MD** is Assistant Professor of Health Informatics at Rutgers University, where his research and teaching focus on leveraging technology and data to address complex challenges in healthcare delivery and public health.*

continued from page 37

Endnotes

1. Teichman PG, Wan S. How to Integrate Clinical Pharmacists Into Primary Care. Fam Pract Manag. 2021;28(3):12-17
2. Institute for Healthcare Improvement. *Improvement Topic: Quintuple Aim*. Accessed November 16, 2025. https://www.ihi.org/library/topics/quintuple-aim.
3. The Patient Care Process for Delivering Comprehensive Medication Management (CMM): Optimizing Medication Use in PatientCentered, Team-Based Care Settings. CMM in Primary Care Research Team. July 2018. Available at: https://www.accp.com/docs/positions/misc/CMM_Care_Process.pdf
4. McFarland MS, Buck M, Armistead L. The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: A Review of the Evidence on Quality, Access and Costs. GTMRx Institute. December 2022.
5. New York State Education Department. Collaborative Drug Therapy Management. Accessed December 5, 2025. https://www.op.nysed.gov/professions/pharmacist/collaborative-drug-therapy-management
6. Pastakia S, Clark A, Lewis K, et al. The impact of clinical pharmacist led comprehensive medication management on diabetes care at Federally Qualified Health Centers within the BD Helping Build Healthy Communities program. JACCP 2021
7. Pastakia SD, Clark A, Lewis K, et al. The impact of clinical pharmacist–led comprehensive medication management on diabetes care at Federally Qualified Health Centers within the BD Helping Build Healthy Communities program. *J Am Coll Clin Pharm*. 2022;5(3):273–282. doi:10.1002/jac5.1586
8. Ulrich IP, Lugo B, Hughes P, et al. Access to clinical pharmacy services in a pharmacist-physician covisit model. *Res Social Adm Pharm*. 2021;17(7):1321-1326. doi:10.1016/j.sapharm.2020.10.002
9. Palandri D, Raber H, Tak C, Bald E, Hastings K, Gunning K. Improving Patient Access to Primary Care Providers Using a Pharmacist-Physician Co-Visit Model. *Innov Pharm*. 2023;14(2):10.24926/iip.v14i2.5106. Published 2023 Oct 10. doi:10.24926/iip.v14i2.5106.

***Jennifer Maguire, MD** is Assistant Professor in the Department of Family Medicine at the University of Rochester in Rochester, NY. She holds the position of Associate Medical Director and Quality Director at her primary care office, Highland Family Medicine.*

***Amy Thein, PharmD** is a Clinical Pharmacy Specialist in the Department of Pharmacy at Highland Hospital. Her primary practice site is Highland Family Medicine. She is also Clinical Assistant in the Department of Family Medicine at the University of Rochester in Rochester, NY.*

Getting to Inbox Zero:

Real Life Strategies for Managing the Digital Side of Family Medicine

By Nikita Gupta, MD

Introduction

In modern family medicine, the patient experience does not end when they walk out the door. It continues through the portal message, the result note, and the ever-growing in-basket. Managing this flow of digital communication has quietly become one of the most time-consuming (and least taught) parts of our job. Yet how we handle these messages can make or break a patient's trust and satisfaction.

Recent studies have shown disparities in how quickly patient-portal messages are answered, with differences seen by race, insurance type, and preferred language.[1] Meanwhile, message burden continues to rise, particularly for female physicians who often receive more patient communication and spend more time managing their inboxes than their male colleagues.[2-4] These pressures raise critical questions. How do we keep up with ever increasing digital communication, ensure equitable care, and still protect our own emotional well-being?

To better understand what works in day-to-day practice, I sat down with some of our clinic's most efficient and well-loved family physicians to uncover their best tips, tricks, and hard-won wisdom for staying on top of their in-baskets while maintaining the human connection that defines family medicine. I share real, practical approaches that any family physician can use, along with a quick-reference summary chart to help turn inspiration into action. Ultimately, my hope is that this article will spark a broader conversation about digital communication in family medicine and how we can make it more equitable and sustainable, for both our patients and for ourselves.

The Growing Burden of the In-Basket

Over the past decade, the in-basket has shifted from a modest stream of follow up tasks to one of the fastest growing sources of physician workload. Across large health systems, primary care clinicians now receive two to three times more electronic messages than they did ten years ago, with sharp increases following the widespread adoption of patient portals and the COVID pandemic.[5-7] Much of this surge reflects not only patient questions but also system generated alerts, which account for nearly half of all inbox items.[7]

As the volume of messages has grown, so has the amount of time clinicians spend outside scheduled work hours completing these tasks. Studies estimate that primary care physicians devote one to two hours each evening to in-basket management, often finishing their inbox at home.[6,8] Persistent after hours inbox work is strongly associated with emotional exhaustion, reduced work satisfaction, and higher odds of burnout.[8,9] National surveys consistently show that clinicians with heavier in-basket burdens are more likely to report burnout symptoms and to feel they lack control over their workday.[9] Taken together, these trends demonstrate that digital communication is not only an operational challenge but a significant contributor to clinician distress.

Equity and Response Times

A recent study in JAMA is a stark reminder that how we manage digital messaging has real equity implications. In their analysis of more than 341,000 messages, only 65.7 percent of threads from Black patients received a response within one business day, compared with 68.5 percent for white patients.[1] For Hispanic patients, the rate was 63.9 percent.[1] Even more pronounced, only 58.0 percent of messages from patients preferring Spanish received a response within a business day, compared with 68.4 percent of messages from English-preferring patients.[1] After adjusting for clinic and timing, Spanish preference remained strongly associated with slower replies.[1]

These disparities suggest that without intentional workflows, the digital channel may perpetuate or deepen gaps in access, trust, and timeliness.

Gender Differences

Research consistently shows that women in primary care receive more digital communication than men, and that this has significant implications for their workload. A large message analysis revealed that female physicians received on average 1,754 patient portal messages, compared with 1,235 for male physicians, equivalent to a 42% increase.[8] Another study found that primary care clinicians with higher inbox burdens were more likely to be female, and were more likely to do that work outside normal clinic hours.[7]

continued on page 45

continued from page 44

Gender-based differences in in-basket workload go beyond the sheer numbers of messages. One study shows that female residents received more "patient advice" portal messages than male residents (about 86.7 vs. 68.0 per year), and spent more time per day on their in-basket.[6] Patient advice messages require deeper clinical assessment, are less easily delegated to other members of the care team, and directly impact the patient-physician relationship. Given these results, it is not surprising that female primary care physicians are more likely to say that managing in-basket messages contributes to burnout than their male colleagues.[5]

These findings underscore that gender imbalances in digital communication are not just statistical, they contribute to longer days, higher emotional load, and significantly increased risk of burnout for women.

Real-World Strategies From Efficient Clinicians

The physicians I interviewed varied in their communication styles and clinic workflows, yet several strategies emerged consistently.

1. **Protect Time for Messaging**
   Efficient clinicians block time for messages at predictable points during the day. Many start the morning with 15 to 20 minutes to clear overnight messages, then revisit the inbox at midday and after clinic. This reduces fragmentation, and prevents backlogs.
2. **Delegate and Triage With Team Support**
   The most efficient physicians utilize the support of their nurses and medical assistants to address common message types such as refills, appointment requests, and normal lab follow ups. This allows them to focus on clinical decisions, new symptoms, or complex questions.
3. **Use Thoughtful Templates**
   Templates can save time without sacrificing connection. Many clinicians maintain a small library of customizable responses for common scenarios such as medication adjustments, lifestyle recommendations, or chronic condition follow up. Personalizing each note helps preserve the relational aspect of care.
4. **Set Expectations With Patients**
   Clear communication during visits is key. Clinicians often explain typical response times in person, such as aiming to reply within three business days, and remind patients that urgent concerns should be addressed by calling the office.
5. **Batch Work and Limit Distractions**
   Rather than responding continuously throughout the day, effective clinicians batch their responses and turn off disruptive alerts that pull them out of their current task. This prevents constant task switching, which contributes to cognitive fatigue and reduces efficiency.
6. **Establish Boundaries for After Hours Work**
   Some clinicians use a fixed cutoff time for portal work, often 20 to 30 minutes after the last appointment. Others set an automatic response indicating that messages received after hours will be answered the next business day. These boundaries are important for sustaining long term wellness.
7. **Use AI Tools With Care**
   AI assisted message drafting is becoming more common. Early research suggests that AI generated drafts are often perceived as empathetic and accurate, although they do not always shorten turnaround times.[10] The physicians I spoke with emphasized that AI should be a support tool rather than a replacement. Clinicians always edit AI generated drafts to maintain accuracy, tone, and relationship centered communication.

continued on page 46

Table 1: Putting It All Together: A Summary Chart

Strategy	Benefit	Practical Tip
Scheduled inbox blocks	Reduces backlog, stabilizes workflow	Reserve 15-30 minutes at start and end of clinic days
Team-based triage	Frees physician time for complex tasks	Delegate common message types like refills and appointment requests
Templates + personalization	Saves time, preserves patient connection	Build and maintain 3-5 "core" template messages
Patient expectation-setting	Aligns portal timing with clinician capacity	Communicate policy (e.g., "Goal: within 3 business days")
Batch processing	Minimizes context-switching distractions	Turn off portal alert pop-ups; process messages in set slots
After-hours boundaries	Protects clinician well-being	Set daily cutoff for message work; use auto-replies
AI tool adoption	Boosts efficiency, supports equity	Pilot AI tools, but always review before sending

continued from page 45

System-Level Considerations

As I dug deeper into evidence-based strategies for improving In-Basket management, it became increasingly clear that while individual skills help, meaningful improvement requires system level support. Health systems can promote sustainable messaging practices in many ways. Here are my suggestions:

1. **Adopt team-based message management.** Studies consistently show that clinics which implement structured triage protocols consistently report lower inbox volume for physicians.[11,12]
2. **Monitor portal response equity.** Systems should track message reply times by patient race, language, and insurance status to identify and correct disparities.
3. **Train clinicians and staff.** Providing education on in-basket best practices, including time management, delegation, and the use of templates, should be part of continuing professional development.
4. **Recognize and compensate asynchronous work.** Organizations should formally account for message-based work in panel size, productivity metrics, or compensation models, and allot dedicated time for its management.
5. **Support AI assisted tools.** Clinics should provide access to and education around the safe and appropriate utilization of AI assisted tools in in-basket management

Conclusion

Digital communication is no longer on the periphery of family medicine, it is central to our work. Managing the in-basket well is not just about efficiency, but about sustaining ourselves, preserving human connection, and ensuring equitable care.

By leveraging structured workflows, setting realistic expectations, and thoughtfully using technology such as AI, we can move closer to "Inbox Zero" without losing the relational essence of family medicine. At the same time, we must advocate for system-level supports that recognize and value asynchronous care. As a community, we can make digital communication work for patients, clinicians, and the future of our practice.

Endnotes

1. Rotenstein LS et al. Patient Physician Messaging by Race, Ethnicity, Insurance Type, and Preferred Language. *JAMA Network Open*. 2025.
2. Branford GM et al. The Gender Gap in EHR Workload. *Journal of General Internal Medicine*. 2025.
3. Gender Disparities in Electronic Health Record Usage and Inbasket Burden for Internal Medicine Residents. *Journal of Graduate Medical Education*. 2024.
4. Couture A, Birstler J. The Gender of the Sender. *Journal of Women's Health*. 2023.
5. Tai-Seale M et al. Electronic Health Record Logs Indicate Split Time Between Patients and Desktop Medicine. *Health Affairs*. 2017.
6. Adler-Milstein J et al. Electronic Patient Messages and After Hours Work. *JAMA Network Open*. 2022.
7. Tai-Seale M et al. Physicians' Well Being Linked to Inbasket Messages. *Health Affairs*. 2019.
8. Friedberg MG et al. The Electronic Health Record Inbox and Burnout. *JAMIA*. 2022.
9. Sinsky CA et al. Allocation of Physician Time in Ambulatory Practice. *Annals of Internal Medicine*. 2021.
10. Tai-Seale M et al. AI Generated Draft Replies in Health Records. *JAMA Network Open*. 2024.
11. Baltaro E. Patient Electronic Messaging: Tips to Save Time. *Family Practice Management*. 2022.
12. Rule A et al. Primary Care Physicians' Experiences With Inbox Triage. *Journal of the American Board of Family Medicine*. 2025.

Nikita Gupta, MD *is a PGY-3 resident physician in the Mount Sinai/Institute for Family Health - Harlem Residency in Family Medicine. A dedicated member of the New York State Academy of Family Physicians, she previously served on the Board as a Downstate Student Representative and contributed to the Public Health Commission. Her interests include health equity, reproductive health access, and physician well-being and burnout prevention.*

The Waiting Game: Delays in Primary Care Access and Their Ripple Effects Across Generations

By Joshua Potter, DO; Sabrina Trammel, DO, and Lovedhi Aggarwal, MD

Introduction

Primary care has been defined in several notable fashions, but a reasonable definition is that it is "first-contact, comprehensive, coordinated, and continuous care..."[1] While this often includes a variety of specialties such as family medicine, internal medicine, general pediatrics, and obstetrics and gynecology, arguably the bulk of the primary care workforce is composed of family physicians: in 2019, family physicians made up approximately 40% of the primary care workforce, placing them at the forefront of any issues facing this particular area of the healthcare system.[2]

One of the most impactful issues facing primary care today revolves around patient access. The Institute of Medicine identified timely access to care as one of the six dimensions of health care quality in their 2001 report, *Crossing the Quality Chasm*.[3] Timely and reliable access to primary care has been associated with improved health outcomes and decreased overall mortality. The public discourse surrounding this issue to date has often focused on physician supply, and rightfully so; an increase of 10 primary care physicians per 100,000 population is associated with a 51.5-day increase in life expectancy, while that same level of increase is associated with a reduction in cardiovascular mortality of 30.4 deaths per million and in cancer mortality of 23.6 deaths per million.[4]

Yet while the data regarding the beneficial impact of ensuring an adequate supply of family physicians are clear, shortages of primary care physicians persist. In 2024, the National Center for Health Workforce Analysis reported a projected shortage of 87,150 full-time equivalent primary care physicians by 2037, a looming public health crisis that is particularly relevant for New Yorkers as 1 in 3 New Yorkers currently resides in an area with inadequate primary care access. [5,6]

However, a number of barriers in addition to physician shortage impede timely access to care. These include such barriers as long wait times for new patient appointments, varying degrees of technological incorporation and acceptance, and difficulties with insurance affordability and acceptance, among others. In 2025, the average wait time for a new patient appointment was 26 days in major metropolitan areas nationwide, with longer wait times for patients in both underserved and rural areas; moreover, even researchers exploring this issue report that simply reaching physician offices to schedule an appointment can be difficult due to the ubiquitous automated telephone sequences and answering services.[7]

Such barriers are significantly compounded when viewed through a generational lens; older generations of patients such as baby boomers often face difficulties when asked to travel the increased distances required to see primary care physicians made necessary by the above-noted physician shortages, and may be less comfortable with technological means of accessing healthcare such as telehealth visits, while younger generations such as generation Z who may be more comfortable with telehealth look less and less to healthcare providers as authoritative sources of information and more to social media and online personalities.[8]

Clearly, improving access to primary care is vital to ensuring improved outcomes for patients, and family medicine must stand at the forefront of addressing the associated barriers and proposing solutions. In this paper, we provide an overview of the extant data regarding barriers to access through a multi-generational lens and propose several practical solutions to improve the patient's experience.

Barriers to Patient Access

If we examine the way in which different generations interact with and access medicine, we can begin to see barriers that are unique to each group. One approach to dissecting the various generational barriers to access is to discuss various system-level versus individual-level factors.

System level factors such as appointment availability, geographic barriers, telehealth infrastructure, and insurance coverage disproportionately affect different age groups. In an article published in the National Health Statistics report in 2022, 12.5% of US adults reported delaying or not pursuing care due to being "too busy," with working age adults affected at higher rates than older adults with less work-related scheduling barriers.[9] While patients from the silent and baby boomer generations may have more flexibility with time and schedules, one particular barrier they may face revolves around transportation in a population that is aging and may have various cognitive limitations. The distance to care, especially for patients living in rural areas, offers greater challenges to accessing the type of in-person care that they are seeking.

For this population, telehealth utilization is often another barrier due to the cognitive limitations experienced with elderly populations, whereas it may serve as an advantage to younger populations for the reverse reasons. In a cross-sectional study of national health and aging trends, it was reported that 72% of adults greater than 85 years of age had difficulty with telehealth video visits due to hearing or vision issues, difficulty speaking, possible or diagnosed dementia, or being unsure of how to use internet-based or wireless technology, including email and text messaging.[10]

continued on page 48

continued from page 47

Lastly, insurance coverage also impacts all ages but presents in a variety of ways. The recent government shutdown provided a vivid example of the myriad ways that coverage of telehealth services for Medicare patients can shift quickly. On the contrary, for younger patients, disruptions in health care coverage such as those experienced during a transition such as aging out of parental employee-sponsored plans at age 26 or aging out of the Medicaid or Chip programs at the age of 19, complicate, deter, and even serve to prohibit many of those in younger generations from seeking primary care at all.

In addition to structural barriers, individual level factors that play a role in the spectrum of generational access to care include hurdles such as technology and health literacy, scheduling preferences, perceived need for care, and health care values. From least to most adept, there is a wide spectrum of digital technology utilization that somewhat increases with each generation chronologically. The silent generation are considered the least comfortable with technology.[11] While boomers are willing to engage with technology, they are not as comfortable as millennials who grew up with the internet and smartphones or generation Z and generation alpha who are more tech savvy as a whole and frequently rely on social media. This natural evolution of technology and the generational experiences create a barrier as healthcare systems try to adapt to modern medicine and adaptation of technology as not all generations are comfortable with or have the knowledge and skills or even trust in a digital intermediary such as a virtual visit.

As older generations such as The Silent Generation and Baby Boomers are generally less tech savvy, they tend to prefer traditional, in-person care and struggle more with conducting healthcare tasks online such as discussing test results, which is another hurdle to accessing medical care.[8,12] On the other hand, for younger generations such as Generation X and Millennials, convenience is of importance as they balance the many roles of working, child-rearing and caregiving, and they often express preferences for convenient digital options and emerging technologies.[8] For this population, technology is a solution rather than a barrier.

Improving the Patient Experience

There are a number of general solutions that may improve patient access to healthcare, and these should be an area of focus for family physicians both individually and as a whole. These include the notable and somewhat obvious interventions that have been and continue to be discussed at the national level such as work to increase funding for primary care residency positions, particularly in rural areas suffering from primary care physician shortages, and robust advocacy for improved recruitment and reimbursement for primary care services from federal and commercial payers.

This need is particularly notable in New York, where there are 190 primary care Health Professional Shortage Areas, encompassing a population of more than 4.7 million, and for whom an estimated additional 1,000 primary care providers would be required for the Health Professional Shortage Area designations to be removed.[13] In addition to increasing the number of primary care providers, we also propose that family medicine residency programs should continue to work to incorporate robust practice management education into their curricula so that future graduates are increasingly well-equipped and prepared to grapple with issues such as patient access.

However, a generationally tailored approach may provide further insights and practical solutions at both the system and individual levels. For example, primary care practices in a variety of locations and settings have long recognized the need for offering appointment times outside of the traditional “9 PM to 5 PM” working hours in order to accommodate the needs of working adults and parents. While such interventions can be impeded at times by the obvious challenges of staffing in terms of front desk workers, nursing, and providers outside of traditional working hours, this system-level intervention remains a vital one for primary care practices interested in surmounting this barrier to access, and there is evidence that this leads to both improved patient satisfaction among patients who work full-time and that after hours care leads to significantly fewer emergency department visits.[14,15,16]

Another system-level intervention that may lead to improved access is for practices to develop strategies to schedule geriatric patients in a grouped fashion, either in the form of scheduling during a specific clinic session for individual visits or in the form of group visits for patients with shared medical issues and needs. Group medical care models have shown promise in improving access and outcomes in general, as noted by Cunningham et al. observing that “group visits have the potential to improve patient experience, health outcomes, and costs for a diversity of health conditions” and Lum et al. noting that advance care planning group visits in geriatric primary care can notably increase advance care planning documentation.[17,18]

Such an intervention makes particular sense in rural communities where the ability of older patients to travel easily to and from the primary care office may be impaired; many of these communities have robust senior citizen services that offer transportation services to mobility-impaired and/or homebound seniors, and in communities where such are not available through senior citizen centers or via community-sponsored programs, there are often county and state level transportation services offered free of charge, and New York has a number of such services.[19,20]

Although such services may certainly not be universal, taking advantage of them in the circumstances where they are available and doing so in a way that multiple patients can be transported to primary care offices during the same timeframe will not only lead to increased efficiency in terms of community resource utilization, but also provide opportunities for improved patient access in terms of easing transportation burden and improved patient outcomes in this population through ensuring additional opportunities for socialization.

At the individual level, there are several potential solutions to the barriers identified above. For instance, primary care practices must recognize the varying levels of technological literacy and comfort across generations and prioritize maintaining multiple opportunities for patient access. While there are many advantages to incorporating such technological tools as online scheduling and

continued on page 49

continued from page 48

automated telephone services and younger generations often seek out practices that offer tech-forward opportunities for access, practices must recognize that, particularly for older generations, these services serve more often as a frustrating barrier that impedes access.

Accordingly, practices should work to incorporate and maintain both avenues of access, not only incorporating strategies such as online scheduling and automated telephone services to alleviate staffing burden but also maintaining a means of directly accessing front desks via telephone for older generations and any other patients who prefer to call and talk to “someone they know” when scheduling appointments. This may require designating front desk staff at times to solely focus on answering telephone calls while other staff focus on checking patients in and out or even training nursing staff to check patients in and out so that front desk staff are always available to answer the phone when necessary, but such practice adjustments will almost certainly lead to improved patient satisfaction and access.

At the same time, primary care practices must recognize the differing levels of technological literacy and provide educational opportunities for patients across generations who are less comfortable with various modalities such as communication with providers via patient portals and online self-scheduling.[21] Frequently, education on technologies such as patient portal access and utilization takes place via ad hoc opportunities where front desk staff educate patients on access and use, but this has been shown to lead to inferior uptake of patient portals compared to in-person interventions.[21] While there has not been significant research into specific interventions utilizing in-person education through the lens of a generational approach, given the varying characteristics and comfort level of generations of patients as outlined above, we propose that this could be a particularly useful approach.

Such educational opportunities could be presented in a variety of ways and include approaches including monthly “courses” in the evenings or on weekends where practice employees meet with new and established patients in a group setting to review the various modalities of access via technological services that the practice provides and provide hands-on training to ensure comfort and understanding. In hospital-owned or larger practices with robust IT departments, this could even take the form of IT employees leading the educational sessions, providing opportunities for improved outreach and engagement.

Finally, primary care practices could consider, where able, assigning nursing staff to patients according to generation. By this we mean that while in many practices medical assistants and nurses are often dedicated to a given provider and there are a number of rationales for this, it may make more sense in a multi-generational primary care practice to group patients by generation. We are not aware of any specific data supporting this approach, but again we propose that such an approach could allow several key opportunities to maximize patient engagement and outcomes.

In this fashion, medical assistants or nurses would work with a given patient population longitudinally and develop the skills and knowledge necessary to risk stratify access and troubleshoot various medical problems according to the issues specific to a given generation. Patient ownership in this approach not only allows dedicated nursing staff to become more facile with the needs of their patient group, but it also could lead to improved patient satisfaction in terms of feeling cared for by a healthcare team shaped around their needs.

Conclusion

Ultimately, improving timely and reliable access to primary care will require far more than simply expanding appointment slots or adding additional primary care residency positions and providers, although such interventions remain vital areas of focus and advocacy for the reasons outlined herein. Above and beyond these steps, however, improving timely access demands a deliberate rethinking of how care is delivered across generations. Delayed access to primary care reverberates through health outcomes, impairs trust in an already fragile healthcare system, and widens inequities substantially accentuated by geography, technology, and insurance instability. Family medicine, with its broad scope and longitudinal orientation, is uniquely positioned to confront these barriers with both system-level reforms and individualized, generation-specific strategies.

A thoughtful combination of expanded hours, creative scheduling models, transportation-sensitive workflows, and dual-path (technological and non-technological) access points provides a practical foundation for improvement. Equally important is the recognition that different generations require different approaches, whether through group sessions that ease mobility barriers for older adults or through digital-forward tools and targeted education that meet patients where they already are.

Ultimately, strengthening primary care access is less about a single intervention and more about sustained, coordinated efforts that honor the diversity of the patients served. By adopting solutions that balance innovation with inclusivity, family physicians can meaningfully blunt the ripple effects of delayed care and work to rebuild a system in which timely access is the rule rather than the exception.

Endnotes

1. Levine, David M., Bruce E. Landon, and Jeffrey A. Linder. 2019. “Quality and Experience of Outpatient Care in the United States for Adults with or without Primary Care.” *JAMA Internal Medicine* 179 (3): 363. https://doi.org/10.1001/jamainternmed.2018.6716.
2. Wilkinson, Elizabeth, Emma Bazemore, and Yalda Jabbarpour. 2019. “Ensuring Primary Care Access in States with an Aging Family Physician Workforce.” *American Family Physician* 99 (12): 743–43. https://www.aafp.org/pubs/afp/issues/2019/0615/p743.html.
3. Institute of Medicine (US) Committee on Quality of Health Care in America. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. *PubMed*. Washington (DC): National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK222274/.

continued on page 50

continued from page 49

4. Basu, Sanjay, Seth A Berkowitz, Robert L Phillips, Asaf Bitton, Bruce E Landon, and Russell S Phillips. 2019. "Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015." *JAMA Internal Medicine* 179 (4): 506–14. https://doi.org/10.1001/jamainternmed.2018. 7624.
5. National Center for Health Workforce Analysis. *State of the Primary Care Workforce: 2024 Report*. November 2024. U.S. Department of Health and Human Services, Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-primary-care-workforce-report-2024.pdf.
6. teamnyshealth. 2025. "Progress for Primary Care - New York Health Foundation." New York Health Foundation. June 12, 2025. https://nyhealthfoundation.org/2025/06/12/progress-for-primary-care/.
7. "Survey of Physician Appointment Wait Times | AMN Healthcare."*Amnhealthcare.com*. https://www.amnhealthcare.com/amn-insights/physician/whitepapers/2025-survey-of-physician-appointment-wait-times/.
8. Cecconi, Costanza, Rob Adams, Antonella Cardone, Joséfine Declaye, Mitchell Silva, Tineke Vanlerberghe, Nick Guldemond, Ignaas Devisch, and Joris van Vugt. 2025. "Generational Differences in Healthcare: The Role of Technology in the Path Forward." *Frontiers in Public Health* 13 (1546317). https://doi.org/10.3389/fpubh.2025.1546317.
9. Ng, Amanda, Adjaye-Gbewonyo, Dzifa, and James Dahlhamer. 2024. "Sociodemographic Differences in Nonfinancial Access Barriers to Care among Adults: United States, 2022.," *Natl Health Stat Report*. https://doi.org/10.15620/cdc/158782.
10. Creber, Ruth Masterson, John A Dodson, Julie T Bidwell, Khadijah Breathett, Courtney R Lyles, Carolyn H Still, Jennifer Yu, Clyde W Yancy, and Spyros Kitsiou. 2023. "Telehealth and Health Equity in Older Adults with Heart Failure: A Scientific Statement from the American Heart Association." *Circulation-Cardiovascular Quality and Outcomes* 16 (11). https://doi.org/10.1161/hcq.0000000000000123.
11. McCrindle, Mark. 2018. *The ABC of XYZ: Understanding the Global Generations*. McCrindle Research.
12. Aslan, Ayse, Freda Mold, Harm van Marwijk, and Jo Armes. "What Are the Determinants of Older People Adopting Communicative E-Health Services: A Meta-Ethnography." *BMC health services research*, January 11, 2024. https://pmc.ncbi.nlm.nih.gov/articles/PMC10785477/.
13. "Primary Care Health Professional Shortage Areas (HPSAs) | KFF State Health Facts." 2025. KFF. August 9, 2025. https://www.kff.org/other-health/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22.
14. O'Malley, Ann S. 2013. "After-Hours Access to Primary Care Practices Linked with Lower Emergency Department Use and Less Unmet Medical Need." *Health Affairs* 32 (1): 175–83. https://doi.org/10.1377/hlthaff.2012.0494.
15. Mou, Liwei, Yiu-Shing Lau, Patrick Burch, and William Whittaker. 2025. "Did a National Extended Access Scheme Translate to Improvements in Patient Experience to GP Services in England? A Retrospective Observational Study Using Patient-Level Data from the English GP Patient Survey." *BMC Health Services Research* 25 (1). https://doi.org/10.1186/s12913-025-12447-9.
16. Whittaker, William, Laura Anselmi, Søren Rud Kristensen, Yiu-Shing Lau, Simon Bailey, Peter Bower, Katherine Checkland, et al. 2016. "Associations between Extending Access to Primary Care and Emergency Department Visits: A Difference-In-Differences Analysis." Edited by Sanjay Basu. *PLOS Medicine* 13 (9): e1002113. https://doi.org/10.1371/journal.pmed.1002113.
17. Lum, Hillary D., Joanna Dukes, Andrea E. Daddato, Elizabeth Juarez?Colunga, Prajakta Shanbhag, Jean S. Kutner, Cari R. Levy, and Rebecca L. Sudore. 2020. "Effectiveness of Advance Care Planning Group Visits among Older Adults in Primary Care." *Journal of the American Geriatrics Society* 68 (10): 2382–89. https://doi.org/10.1111/jgs.16694.
18. Cunningham, Shayna D., Ryan A. Sutherland, Chloe W. Yee, Jordan L. Thomas, Joan K. Monin, Jeannette R. Ickovics, and Jessica B. Lewis. 2021. "Group Medical Care: A Systematic Review of Health Service Performance." *International Journal of Environmental Research and Public Health* 18 (23): 12726. https://doi.org/10.3390/ijerph182312726.
19. Kaye, Neva. 2019. "Toolkit: State Strategies to Support Older Adults Aging in Place in Rural Areas - NASHP." NASHP. September 12, 2019. https://nashp.org/toolkit-state-strategies-to-support-older-adults-aging-in-place-in-rural-areas/.
20. "New York Senior Transportation Resources." n.d. Www.eldercareresourcecenter.info. https://www.eldercareresourcecenter.info/senior-transportation-resources-new-york.php.
21. Lyles, Courtney R., Eugene C. Nelson, Susan Frampton, Patricia C. Dykes, Anupama G. Cemballi, and Urmimala Sarkar. 2020. "Using Electronic Health Record Portals to Improve Patient Engagement: Research Priorities and Best Practices." *Annals of Internal Medicine* 172 (11): 123–29.https://doi.org/10.7326/m19-0876.

***Joshua Potter, DO**, is Clinical Assistant Professor in the Department of Family, Population, and Preventive Medicine at SUNY Stony Brook and serves as Associate Program Director of the Family Medicine Residency Program at Stony Brook Southampton Hospital. He completed his residency in integrated family medicine & neuromusculoskeletal medicine at Stony Brook Southampton Hospital. His professional interests include undergraduate and graduate medical education, diagnostic reasoning, osteopathic manipulative medicine, and full spectrum family medicine.*

***Sabrina Trammel, DO**, is Clinical Assistant Professor in the Department of Family, Population, and Preventive Medicine at SUNY Stony Brook and serves as Associate Program Director of the Family Medicine Residency Program at Stony Brook Southampton Hospital. She completed her family medicine residency and fellowship in palliative care at Stony Brook Southampton Hospital and earned a Master's degree in healthcare administration from Cornell University. Her professional interests include preventive care, resident education, and addressing social determinants of health.*

***Lovedhi Aggarwal, MD** is Professor in the Department of Family, Population and Preventive Medicine at SUNY Stony Brook and serves as Program Director of the Family Medicine Residency Program at SUNY Stony Brook, Southampton. He completed his family medicine residency at Middlesex Hospital in Middletown, CT and fellowship in geriatric medicine at SUNY Stony Brook. His interests include eliminating health disparities, resident education, and cost-conscious care.*

When Patient Experience Shocked Traditional Medicine

By Thomas C. Rosenthal, MD

As medical scientists, we like to believe that peer-reviewed, published research produces facts we can integrate into our knowledge base and apply with limited interpretation.[1] However, even limited uncertainty clashes with the human desire to feel in control; and a sense of control gives one the feeling that values, wants, and self-esteem can be harmonized. In medicine, patients generally lack the opportunity or the time to accumulate the medical knowledge expected of physicians. Consumer sampling is more hit-or-miss, and therefore vulnerable to the sales pitch of patent medicine salesmen and politicians.[2] In the nineteenth-century a feud between allopaths* (regular medicine) and homeopaths (the law of similars) represents a major tipping point for medical science, much like Americans face today.

In 1875, Philadelphia allopathic physician Horatio C. Wood (1851-1920) was called for a second opinion on a patient another allopath had diagnosed with "intestinal inflammation and paralyzed bowels." The first allopath bragged that he was no homeopath and did not deal in infinitesimal dilutions and had given the patient massive doses of cathartics (120 grains of mercury salts, half an ounce of turpentine, and 28 drops of crotón oil) over several days. Dr. Wood found the patient in a dreadful state and in great pain. When the patient died a few hours later, Wood declared he had been a "victim of legalized murder" by heroic medicine.[3]

Would this patient have been cured if they had chosen the advice of a homeopathic doctor whose treatments would have been limited to dilute infinitesimals? Might his death have been less traumatic? Like it or not, a segment of Americans feel they confront a similar issue today. Vaccines have been so successful that their infinitesimal risk looks as if it exceeds that of natural disease. Few practicing physicians, and virtually none of our patients, have experience with the dreadful encephalopathy of measles or the helplessness of polio.

Word of Samuel Hahnemann's (1755-1843) system of homeopathy reached the United States shortly after Hahnemann's first book was published in 1796. In 1834, Hans Burch Gram landed in New York City and established the first medical practice dedicated to Hahnemann's principle of 'similia s-irnilibus curantur' (the law of similars). By 1841, a New York City homeopathic society was established, followed a few years later by the National Homeopathic Medical Society.[4] Homeopathic doctors carried kits with a dilution labeled for every ailment and precise directions for their use. To the layperson, it seemed more scientific than the trial-and-error practice of most regular practitioners. By the middle of the nineteenth-century, nearly 40% of patients sought care from a homeopathic doctor before they would call an allopath.[5]

Most allopaths doubted the effectiveness of Hahnemann's dilutions, and most homeopaths dismissed allopathic practice as being harsh and equally unproven. Both systems competed with other alternatives.[4,6] On the frontier, Native American medicine men were held in high regard. There were also herbalists, hydrotherapists and purveyors of patent medicines that claimed to cure most everything. Regular physicians tried to dismiss them as "irregulars" or "sectarians," but in America, every citizen had the right to choose whatever remedies they wished.

In New York, herbal doctors known as Thomsonians amassed over 50,000 signatures on a petition demanding full licensure and recognition. In 1844, the New York legislature was so bewildered that they removed all training prerequisites for obtaining a medical license.[7] By 1860, the first New York homeopathic medical college was opened in New York City, and by the 1870s, 55 homeopathic medical schools competed with 52 regular medical schools, though many "regular" doctors were trained by apprenticeship. Inconsistent laws governing medical practice in the United States had fostered the growth of homeopathy well beyond that seen in Europe.[8]

When a deadly epidemic of cholera returned to the United States in 1848, public health records in Philadelphia and New York exposed an embarrassing truth. Patients had a slightly better chance of surviving cholera if cared for by a homeopathic practitioner. The findings forced regular doctors to begin a long, gradual abandonment of bloodletting and purging and an honest appraisal of the emerging germ theory.[8]

Dr. N. H. Warner offers an example of medicine's internal conflict. A graduate of the traditional medical college at Yale, Warner started practicing

continued on page 52

Homeopathy Looks at the Horrors of Allopathy, **an 1857 painting by Alexander Beydeman, showing historical figures and personifications of homeopathy observing the brutality of medicine of the 19th century**

**Hahnemann labeled regular doctors allopaths. He meant it as a derogatory term meaning "other pain."*

continued from page 51

in Buffalo in the 1840s. As more of his patients protested bleeding and purging, he incorporated homeopathic dilutions into his practice and finally embraced homeopathy exclusively. Warner was a quiet, dignified man, with a magnetic presence and quick insight, but when he denounced his allopathic brethren in public, he was expelled from the county medical society.[9] He became one of the three-hundred homeopaths practicing across New York State in 1852. By 1870, he was joined by over 727 practicing New York homeopaths.[10]

In 1857, the New York Legislature dealt with the licensure conflict by approving a parallel system of county homeopathic medical societies that mirrored the allopathic societies. Just like the allopathic societies, these new societies had the power to grant homeopaths a license to practice medicine.[4] Soon homeopathic hospitals opened, and Buffalo's Dr. Warner became editor of a homeopathic journal.[9] Homeopathic medical colleges advertised that their instruction in anatomy, pathology, and the medical sciences was enhanced by additional instruction in 'similia s-irnilibus curantur.'[4]

This split medical system strained the Code of Medical Ethics that had governed the Medical Society of the State of New York since its adoption in 1823 and had been used as the model for the AMA code of ethics adopted in 1847. The code stated that medical society members would be practicing quackery if they provided consultation to any non-allopathic practitioner.[10] By the 1870s, a core of New York Medical Society members questioned the harm visited on patients when regular doctors refused to consult on cases under the care of homeopaths. To address this concern, the New York State Medical Society revised its code of ethics in 1882.[8] Within months, the AMA accused the New York delegates of violating the AMA Code of Ethics and refused to seat them at their 1882 national meeting.[8]

The next year, 1883, a conservative majority in the Medical Society of the State of New York got the new code repealed, but that left New York with no official code of ethics. The conservative faction then formed a new statewide society called the New York State Medical Association and quickly adopted the AMA code of ethics. For the next twenty-plus years, New York had three medical societies, two rival allopathic groups and the homeopathic society.[10]

Homeopathy won the hearts and pocketbooks of nineteenth-century Americans because homeopathy demanded less and traditional medicine flunked introspection. Today, arguments along similar lines might be made for over-diagnosis of cancer, overuse of psychoactive drugs, antibiotics, spinal surgeries, and overtreatment of terminal patients.[11]

Just as the germ theory resuscitated the scientific roots of allopathic medicine, the twenty-first century may force medical science to reorient itself to meet public demand for candid outcome measures and patient-centered engagement. Instead of silos for primary care, urgent care, hospital care and specialty care, Americans seem to want something different. They'll credit medical science for its advances, but worry that it is oversold. Homeopathy proved that when medical science fails to address a society's anxiety, consumers generate magical dogma and spectacle. As the science fiction writer Isaac Asimov suggested, practitioners might do better by saying "that's interesting" instead of thinking their only option is "Eureka!"[12]

The COVID-19 pandemic reminded Americans that medical science cannot solve all of humanity's problems. When society faced questions that lacked answers, traditional medicine circled the wagons and stuck with quarantines. Despite spending more money than any other country on healthcare, the pandemic also reminded people of the regularity with which even the most scientific studies produce different outcomes. Reassurance and certitude fizzled, and with it the social contract between science and society fractured.[13] As a result, defunding the Centers for Disease Control and Prevention, the Environmental Protection Agency, and the National Institutes of Health has raised little noise outside of academia.[1]

The issues about the code of ethics in New York State were settled when licensure authority was taken away from the professions and reassigned to the State Board of Regents. Defined education standards moved homeopathic remedies to a few bottles on the pharmacy's back shelf. The opposition may be less organized today, but American medical organizations and their practitioners must embrace community health more strongly, or wait until legislatures elevate some new twenty-first-century equivalent of homeopathy backed up by false hopes and magical thinking. Science is the gift allopaths bring to the bedside, but our patients are telling us to make adjustments. Family medicine has been saying it for a long time. Primary care and continuity relationships are the only way to advance science applications, prevent illness, perfect access to specialized care, and assure patient fears are heard, understood, and acted upon.

Endnotes

1. Kluger, J. and J. Worland, *How a War on Science Could Hurt the U.S. and Its Citizens*. Time, 2025.
2. Schwartz, S.H., *Universals in the Content and Structure of Values: Theoretical Advances and Empirical Tests in 20 Countries*. Advances in Experimental Social Psychology, 1992. 25: p. 1–65.
3. King, L.S., *Xvii. Medical Education: Elitisms and Reform*. JAMA, 1983. 250(18): p. 2457–2461.
4. King, W.H., *History of Homeopathy and Its Institutions in America*. 1905, New York: Lewis Publishing Company.
5. Starr, P., *The Social Transformation of American Medicine*. 1982, United States: Harper Collins Publishers.
6. Warren, L., *Constantine Samuel Rafinesque: A Voice in the American Wilderness*. 2015, Lexington: University Press of Kentucky.
7. King, L.S., *III. Medical Sects and Their Influence*. JAMA, 1982. 248(10): p. 1221–1224.
8. Kaufman, M., *Homoeopathy in America*. 1971, Baltimore: Johns Hopkins.
9. Potter, W.W., *A Century of Medical History in the County of Erie, 1800-1900*. Buffalo Medical Journal, 1898. 38(4): p. 260–276.
10. Walsh, J.J., *History of the Medical Society of the State of New York*. 1907, New York, NY: Medical Society of the State of N. Y. 216.
11. Patel, V.R., A.S. Adamson, and H.G. Welch, *The Rise in Early-Onset Cancer in the US Population—More Apparent Than Real*. JAMA Internal Medicine, 2025.
12. Stevenson, L. and D.L. Haberman, *Thirteen Theories of Human Nature 7th Edition*. 2017, London: Oxford University Press.
13. Schulman, A., *The Power of Science to Solve Problems Is Almost Limitless*, in *The New York Times*. 2025: New York.

***Thomas C. Rosenthal, MD** is Professor and Chair Emeritus of Family Medicine at the University at Buffalo. His newest book is titled,* Cyrenius Chapin: Buffalo's First Physician, War of 1812 Hero.

ReMEMBER your BENEFITS!

- NYSAFP Membership Provides:
- Advancing our Specialty, Saving Members Time, Maximizing Values of our Dues
- Representation at the AAFP
- Representation of the local county chapters at the NYSAFP Congress of Delegates
- Promotion of family medicine in the medical schools and support of student programs
- Support of family medicine residency & fellowship training programs
- Representation of family medicine in the federal & state legislatures and policy makers through the PAC
- Saving Members Time
- Hosting of relevant and interactive CME workshops
- Hosting of ALSO instructor and provider courses
- Opportunity to interact with fellow family physicians throughout the state
- Reliable source of relevant and current events
- Weekly e-NewsBrief
- Quarterly peer reviewed journal – Family Doctor
- Timely access to current events of Academy via social media (NYSAFP Facebook | NYSAFP Twitter)
- Maximizing the Values of our Dues
- Sponsorship of students and residents to Academy meetings (Winter Weekend, Regional Family Medicine) and the Congress of Delegates
- Cultivation of the next generation of family physicians by offering scholarships and awards to pre-medical students, medical students, and residents to participate in family medicine conferences and programs
- Support of residents and new physicians in development of leadership skills and practice opportunities
- AAFP Member Services: http://www.aafp.org/online/en/home/membership/resources.html
- A list of the AAFP professional resources
- A list of the AAFP "Member Advantage"
- Additional Partnerships: http://www.nysafp.org/index/resources-6/partner-programs-106.html
- Jobs Board