

Washington State Primary Care Workforce: Summary of Physician Focus Group Findings

Barbara Matthews MBA, Thea Mounts MA

Background

The Affordable Care Act (ACA) contains many provisions that will impact primary care in Washington State. Two key provisions, the individual mandate and the expansion of Medicaid coverage to all non-Medicare eligible persons under age 65 with incomes up to 133%¹ of federal poverty level, are expected to greatly increase patient demand for primary care. This raises questions about physician workforce capacity to meet the new level of demand. Significant changes to health care delivery models are also expected. To learn more about how these provisions might affect primary care in Washington State, the Washington State Office of Financial Management conducted five focus groups of primary care physicians in five areas of Washington State. The primary objective was to obtain physicians' perspectives of factors affecting access to primary care, especially for Medicaid patients, and how the ACA will change the primary care physician's role in the health delivery system. Questions focused on four areas: (1) building the primary care workforce, (2) acceptance of Medicaid and capacity, (3) new delivery system models, and (4) anticipated impact of the ACA. Physicians were also asked what they would say to the Governor if they had a minute to talk about Washington's health delivery system.

Key Findings

The predominate themes expressed by most of the physician focus groups were:

- If the Medicaid reimbursement rates were set at an appropriate level, the physician workforce could serve the expanded Medicaid population.
- Difficulties with claim processing both for Washington State Medicaid and for private insurance negatively affected physician productivity.

1. With a 5% income disregard, the level is effectively 138% of federal poverty level.

- Within medical schools, medical students were discouraged from selecting primary care residencies.
- Reimbursing primary care physicians at a level more equitable to sub-specialists and on a service rather than procedure basis would make primary care a more financially viable choice.
- Mentoring of young adults by rural community physicians could encourage interest in primary care.
- Significant deficits of specialist care for Medicaid patients, especially mental health, exist.
- Medical Homes potentially provide a structure that could make health care more efficient and productive.

Detailed Findings

(1) Building the primary care workforce: determine why the physicians chose primary care, what they felt would encourage others to do the same, and what were disincentives for entering a primary care specialty

INCENTIVES

Participants cited these incentives for choosing primary care.

Altruism. Many physicians had a deep desire to better humankind and care for others.

Mentoring. Mentors or role models often encountered during medical school or residency training influenced physician choice.

Continuity of Care. Physicians appreciated seeing the outcome as they followed their patients over the course of treatment. They also enjoyed becoming part of the community as they cared for multiple generations of families. The variety of coordinating the care of patients in the clinic, with sub-specialists, and in the hospital was also rewarding.

Caring for Kids. Several pediatric primary care physicians liked working with kids, had more fun, and laughed more on their pediatrics rounds and in their pediatrics practices.

Author Affiliations: Barbara Matthews, Department of Family Medicine, University of Washington School of Medicine
Thea Mounts, Washington State Office of Financial Management

Challenging Work. Most participants viewed primary care as requiring great mental acuity and agility. Patient cases spanned many issues and were not routine or predictable, unlike the work of sub-specialists, which they saw as narrow and more predictable. Many primary care physicians saw themselves in the role of triage in ensuring the complete care of their patients.

“Anyone that followed me around in my practice for a few days would understand that what I do is incredibly complex and affects people[s] lives in a profound way [and] makes a big difference to whether or not they actually will require sub specialty care in the future.”

ENCOURAGEMENT FOR OTHERS

Increasing Primary Care Specialty Selection. Participants, especially those within rural practices who had benefited from mentoring, felt that mentoring and outreach programs that targeted young adults in rural areas might encourage more young adults to consider primary care and then return to their communities to practice. Participants mentioned funding of residency tracks in rural settings and a loan payback program for rural community service for a defined term as ways to encourage physicians into rural settings.

DISINCENTIVES

Physicians mentioned these factors, which discourage entering or continuing in primary care.

Inferior Status. Many physicians encountered medical school instructors who advised them not to choose a primary care residency because primary care was not “good enough” or they were “too smart” for primary care. That sub-specialty departments in medical schools can secure more clinical and laboratory research dollars than primary care was also thought to contribute to this attitude in academic circles. This inferior status continued in interactions with other physicians, with hospital administrators who discounted the value of Family Medicine physicians, and with policy makers. Participants felt that primary care physicians had a smaller voice in policy setting because they were as a group a minority relative to all other physicians who were sub-specialists.

Inadequate Compensation. Participants reported two significant financial factors that discouraged physicians from entering primary care. First, primary care physicians earned far less than sub-specialists did. Second, reimbursing for procedures rather than service caused a disparity in charges between primary care and sub-specialty physicians. A physician clarified that the Relative Value Scale Update Committee (RUC) of the American Medical Association,

which was heavily dominated by sub-specialists, developed this procedure based payment model for Medicare. This model served as a standard for other insurances. Physicians expressed dismay at the level of pay that Physician Assistants and Nurse Practitioners could garner for much lower training requirements and knowledge. Low pay coupled with large medical school loans were thought to be a deterrent for many considering a primary care specialty.

“There’s a huge emphasis on paying for procedures because people understand procedures.”

Administrative Barriers. Many physicians complained about the difficulty in processing claims through the State Medicaid system. Insurance companies also presented challenges. Patients’ insurance providers changed as they changed jobs or the employer changed insurance providers, which affected the coverage of services and prescriptions and subsequently the continuity of the patient’s care. Insurance companies set policies for coverage that negatively affected the patient’s care. Physicians found it burdensome to keep up with allowable claims among so many insurance providers. Several physicians expressed the desire for a limited set of formularies available through all insurance companies. Physicians expressed that the additional overhead to manage chronic pain patients [with new State requirements], as well as the associated risk, would cause difficulties.

“If you think about how much of my resources, not just personally but of my staff, that I maintain are directed towards fighting to get reimbursed or fighting to get medications for patients. None of this is directly actually giving the patients care and so right now we’re wasting a huge amount of man power in dealing with bureaucracy as opposed to dealing with medical care...”

(2) Acceptance of Medicaid and capacity: determine the physicians’ level of Medicaid practice and factors that might impact the state’s ability to meet the needs of an increased population of Medicaid patients through the existing workforce

Clinically Complex Patients. Participants reported that Medicaid patients were complicated to treat because they had greater constellation of medical issues including mental health problems and care requiring sub-specialists. Physicians

reported that mental health care specialists were nearly non-existent for Medicaid patients, especially in rural areas. Several physicians reported serving the mental health needs of their own patients. Sub-specialists who treated Medicaid patients were also difficult for the physicians to find, especially in rural areas. The high no-show rates of Medicaid patients exacerbated the problem. In spite of these challenges, physicians felt a moral imperative to treat Medicaid patients and they also enjoyed their Medicaid patients.

Reimbursement Insufficient. While one respondent praised Washington State Basic Health as it was originally conceived, most expressed that the current system and reimbursement rates were not financially viable. Except for the physicians practicing in Federally Qualified Health Centers, all restricted the number of Medicaid patients they accepted. Physicians reported that billing difficulties, including delayed payments and rescinded overpayments, caused countless hours of staff follow-up. Communicating with the State Medicaid department was difficult and unpleasant. Physicians felt burdened by “unfunded mandates” from the State for more reporting requirements, but with no compensation for the extra work. One physician said these billing issues caused him/her to stop taking Medicaid patients. Another said that additional requirements would affect his willingness to continue taking Medicaid patients.

“If you increase my hassle factor, do audits, throw more paperwork, more bureaucratic requirements at me, I’m out of the game.”

Electronic Medical Record Systems Problematic. For some physicians, especially solo practitioners, the capital costs for converting to an electronic medical record (EMR) were prohibitive. Participants also complained about the inadequacy of systems to maintain the patient’s health record so that the physician could track the patient’s progress. Others described the conversion to be difficult. Some were unable to absorb the cost of evaluating potential systems, let alone converting to a system.

(3) New delivery system models: determine the role of the physician and non-physicians in alternate care models

Medical Home. Physicians liked the idea of adding physicians assistants (PAs), nurse practitioners (NPs), case managers, care coordinators, and social workers to their offices, and thought their best usage was for coordinating and monitoring patient care, educating patients, and encouraging preventative care. Participants thought the medical home model was a way to both lessen the burden on the physician through utilization

of non-physicians, but more importantly to keep patients on track in their treatment. Several physicians complained that the NPs they hired and trained moved quickly onto higher-paid specialty care.

“A medical home really is just really good primary care. It’s wrap-around services so that a patient is cared for in a place.”

Patient Accountability. Participants would like patients to be more accountable for their own health care. Suggestions to achieve this goal included patient contracts to promote preventative care practices, providing an incentive of lower premiums, or providing patients with an individual health care fund that could lead to a refund, if the patient followed best practices such as waiting to see their primary care provider the next day instead of using the emergency room at night. Disincentives such as co-pays for visits and of following up with patients in their use of emergency rooms would help discourage inappropriate use.

“I think any model that encourages preventive medicine will be cost effective.”

“If they come in and get their cholesterol checked and they lose weight...there’s a bonus or a gift card or something, we need to get them engaged in their own care.”

Using Technology. Physicians in urban areas could see many possibilities with using e-mail, text, group visits, the internet, or phone calls instead of office visits, if the physicians could bill these services. Physicians in rural areas did not volunteer alternate technology as a means for providing care.

“If you want to get a hold of me text me, you know? This is the world now. [instead of] driving 20 minutes, waiting for 30 minutes, seeing me for 10 and then going home.”

Extended Hours. Physicians acknowledged that patients needed to have after-hour access to primary care.

(4) Anticipated impact of the ACA: determine the impact of the ACA on the physicians’ practice

Capacity to meet Medicaid Populations. Participants in most focus groups believed that the current physician population had the capacity to absorb the increased number of newly qualified Medicaid patients that would result from expanding Medicaid to 133% of the federal poverty level. If Medicaid reimbursements were set at an appropriate amount, many physicians would reconsider limits they had set. Physicians in the rural west area seemed to accept a greater percentage of Medicaid patients, so it was not clear if capacity to accept more patients was possible in that area.

Continuity of Care. Physicians expressed that the expanded coverage through insurance mandates under ACA would support their objective for continuity of care—more patients could have ongoing coverage. However, they were concerned for people who might remain uninsured even with the ACA changes.

Accountable Care Organizations. Physicians feared the bundling provisions of Accountable Care Organizations, for three primary reasons: a) There would be limits to how many organizations physicians could join; b) The primary care portion of the charges, because in the hands of the hospital, would not be priced correctly; and c) Exceptional patient cases that required more treatment would not be adequately priced.

Messages to the governor: participants were asked what they would say to the governor if they had a minute to talk about Washington State’s health delivery system

Medical Education. Eleven physicians called for reform of the medical school education to place more emphasis on primary care. Suggestions included changing the focus of medical school to training of primary care specialties rather than training of sub-specialties; recruiting students more favorably disposed toward primary care; providing support to young adults in rural settings to enter primary care; incentivizing medical students to select primary care; and funding primary care residencies in the more rural areas.

Insurance. Two physicians called for a national health system and asked for committed support of the ACA.

Efficiencies. Three physicians wanted the Governor to seek input and feedback from physicians and physician associations and to observe the delivery of health care first hand in the real world. Two physicians wanted to streamline the Medicaid reporting process for less administrative work. Others suggested managing Medicaid more efficiently like the Uniform Medical Plan; cutting costs and increasing resources through primary care and medical homes; providing universal access to patient records; supporting preventative care; and ending for-profit health care.

Funding. Several physicians suggested increasing taxes to improve State revenue; taxing fast food, sugar and cigarettes—source of much of the disease burden; increasing primary care reimbursements; and distributing budget cuts across all State departments.

Accountability. To increase accountability of the patient, physician, and facilities, physicians suggested standardizing on evidence based medicine across the state so that physicians practice similarly; tightening accreditation for pop-up ERs and surgery; engaging patients through public health programs; and holding patients more financially responsible for their own medical care by giving dollars to the patient as opposed to a claims-driven system.

Methods

In December 2011, five physician focus groups were conducted with primary care physicians from the Internal Medicine, Family Medicine, Pediatrics, Obstetrics/Gynecology, and Geriatrics specialties.² Participants were recruited from mail survey participants who said they were willing to be contacted for further research. The focus groups were held with physicians from five geographic areas in Washington State: urban western (Seattle); rural western; urban eastern (Spokane and Tri-Cities); and rural eastern. To be included, the physicians must have provided direct care for ambulatory patients in Washington State and must not have been within five years of retirement or be “semi-retired.” The 90-minute-long focus groups were held by conference call, except in Seattle, where a face-to-face focus group was held.

Twenty-five physicians participated in the focus groups: eight in Seattle, five in Spokane, and four each in the rural areas and Tri-Cities. Fifteen of the physicians were male and ten were female. Seven were under 40 years old, eight were between 40 and 49, and ten were 50 or older. Eleven were in Family Medicine, six in Internal Medicine, six in Pediatrics, one in General Medicine, and one in Obstetrics/Gynecology. Nine worked in a Health Maintenance Organization (HMO), nine in private practice, and seven in a Community Health Center. Each focus group had at least one person representing each of the above categories with the exception of General Medicine and Obstetrics/Gynecology. The Rural East group had no one in the oldest age category, the Tri-Cities had no one in the youngest age category, and the Tri-Cities had no one from an HMO. Of those in private practice, six were in a group practice and three in a solo practice. Three physicians had attended medical school in Washington State and five participated in a Washington State residency program.

2. Gilmore Research Group in Seattle recruited and conducted the focus groups on behalf of the Office of Financial Management (OFM). The focus groups were funded through a Department of Health and Human Services, State Health Access Program grant.

A standard qualitative analytical approach was taken by first categorizing and coding response passages within each focus group. These categories were thoroughly analyzed across all focus groups to determine salient themes. Differences between rural and non-rural groups were noted within the text.

Note: [brackets] indicate editorial clarifications.

Funding

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Appendix A. Focus Group Questions

1. Building the Workforce

First I have some questions about building the physician workforce.

- a. Thinking back, what were the key determinants in your decision to specialize within one of the primary care specialties?
 - i. (Examples of probes) Why did you choose either of those over other specialties?
 - ii. What was attractive to you about the kind of work you would be doing and patients you would care for under those specialties?
- b. What types of changes are needed in the medical education system and/or the health delivery system to entice new physicians to enter primary care specialties?

2. Acceptance of Medicaid and Capacity

Next, I'd like to ask about:

- a. What are the key determinants in your/your practice's decision to accept or not accept Medicaid patients?
- b. Other than reimbursement rates, what changes to the Medicaid system would cause you to accept (or not accept) additional Medicaid patients?
- c. How will the addition of up to 400,000 newly insured individuals in Washington State and the increase in primary care reimbursement rates under the Affordable Care Act affect your willingness to accept Medicaid patients?
- d. With many newly covered individuals seeking health care services, what changes do you think need to happen in order for the state to have the capacity to handle the increased demand?
- e. What role do you see in your own practice for non-physician practitioners such as physician assistants and advanced registered nurse practitioners?

3. Anticipated Impact of the Affordable Care Act

Our next topic is the anticipated impact of the Affordable Care Act.

- a. On a scale of 1 to 5, to what degree are you following developments with the Affordable Care Act? (5 = extremely closely and 1 = I hardly pay attention.) (Please record your answer on the pad in front of you and then we'll go around the room and discuss.)
- b. What features of the Affordable Care Act are you most concerned about or interested in?
- c. What types of changes do you intend to make to your practice over the next several years as the Affordable Care Act is phasing in? And what barriers, if any, do you face in making these changes?
- d. In your opinion, what do you feel is the state's proper role in encouraging innovation in the health care delivery system particularly with regard to containing costs, improving quality of care, and enhancing health outcomes?

4. New Delivery System Models

Now I'd like to address a number of the new delivery system models that are emerging:

- a. How do you see the movement toward using new models of care such as medical homes, health homes, and accountable care organizations changing the quality of patient care in Washington?
- b. How do you see your practice changing to better integrate mental health services and other behavioral health services with the care you provide?
- c. What resources do primary care physicians need to effectively divert patients from seeking unnecessary care?

5. Wrap-Up Questions

Finally, I just have a few wrap-up questions:

- a. Suppose you had one minute to talk to the governor about Washington's health delivery system. What would you say?
- b. Have we missed anything?