

2006 WHATCOM COUNTY HEALTH CARE PROVIDER ACCESS SURVEY

Introduction

Western Washington University's Small Business Development Center (SBDC) contracted with Whatcom Alliance for Healthcare Access (WAHA) to conduct a confidential survey of Whatcom County physician based practices. The survey was designed to assess existing and potential gaps in physician services offered in Whatcom County with the ultimate goal of targeting limited WAHA resources towards those specialties most needing attention.

Federal law has requirements of hospitals providing community recruitment assistance in areas of critical needs. The areas of specialty receiving monetary assistance must be supported by current data showing population-based need. Also, the Recruitment and Retention program developed by WAHA has criteria for assistance which is focused on increasing access to care in areas of critical need for the community. Therefore, current factual data is needed on physician supply and population-based demand, and the resulting gap analysis.

In addition, the survey was an opportunity to inform other parts of the work of the Recruitment and Retention program by finding out about qualitative and self-reported aspects of physician practice in Whatcom County. In addition to the numerical analysis, physicians were asked for their opinions about access issues, recruitment factors, and their future plans which could affect supply.

Methodology

The Community Recruitment and Retention Committee was involved in every step of the survey; from design and methodology to development of strategies to increase response. At times, there was a focused working subcommittee which included representatives from Saint Joseph Hospital (SJH) and Madrona Medical Group. The Medical Society was actively involved in most phases of the survey, and was especially instrumental in obtaining responses from physicians.

The Community Recruitment and Retention Committee identified 337 physicians practicing in 95 practices that needed to be surveyed. Two different surveys were created. A web based survey (see Appendix A) was created to be responded to by office administration personnel and another print survey (see Appendix B) was formulated to be responded to by physicians. The decision to create two surveys was driven by:

- Who could respond accurately to the question: it seemed that for certain questions, the office manager could respond best on behalf of the practice, and for others, the physician would need to answer in an individual and confidential manner.

- Length: the questions were distilled from a much larger question set until it was felt that the essential questions were being asked. It seemed appropriate to divide them even further into a set for the office manager and a set for the physician. Something similar had been done in the past in terms of surveying the provider community, and it had received adequate response.
- The best vehicle for each audience: it was thought that the office managers would already be on computer much of the day and that a computerized practice survey would be most appropriate for them. For physicians, it was thought that they are not on computer as much, and it would be more convenient for them to take a print piece with them and fill it out wherever they were (office, hospital, home, etc.) when they had a moment..

Gap Analysis

The following analysis (see Appendix C) was designed to assess existing and potential gaps in physician services offered in Whatcom County with the ultimate goal of targeting limited WAHA resources towards those specialties most needing attention. The data gathered was analyzed in three independent phases and each phase was considered in the final recommendation.

Gap Analysis Methodology Assumptions:

The following assumptions were applied in the analysis of the information obtained via the 2006 web-based physician practice survey.

- Solucient population based data was used as a benchmarking tool in phase one. Solucient is a leading information products company that maintains the nation's largest healthcare database.
- MGMA (Medical Group Management Association) productivity based data was used as a comparison tool in phase two. MGMA is a national membership association that provides information, networking and professional development for medical group administrators.
- A WAHA subcommittee comprised of Penny Roberts, Chris Thompson, Dr. David Lynch and Sue Sharp along with a review of a physician directed survey provided essential local industry information used in phase three.

Phase one analyzed the actual number of Whatcom County FTE physicians per specialty compared to Solucient national averages adjusted for Whatcom County population. This analysis projected an under/over supply for Whatcom County. Critical under supplies were rated a one, moderate under supplies were rated a two and over supplies were rated a three.

Phase two analyzed physician productivity levels per specialty compared with MGMA national averages. This analysis helped to determine practice culture and to identify where additions or productivity improvements could be made.

Phase three of the gap analysis incorporated qualitative information from the WAHA subcommittee and the physician directed survey. This information was imperative to our analysis as the subcommittee comprises both physicians and administrative staff with a strong local knowledge of Whatcom County healthcare. The following list provides qualitative information provided per selected specialty in order to justify final recommendations:

PHASE THREE SPECIALTY ANALYSIS

Endocrinology

There is adequate physician supply at this time. It appears from the data and qualitative review that this specialty needs to be monitored for adequate supply in future years.

General Surgery

The population and productivity based data indicate a need for recruitment in this area. The committee felt that due to low wait times (2 to 3 weeks) in this specialty, other areas were a more significant concern and therefore rated this specialty as a priority level 3.

Neurology

At the time of this survey, there remains a deficit of physicians practicing in this specialty. Two physicians are locating in Whatcom County this summer. Due to these factors the committee rated this specialty a priority level 3.

Orthopedics

Participating practices are actively recruiting to meet needed gaps and therefore, this specialty is not a priority for the committee at this time.

Otolaryngology

While the committee recognizes that the data indicates a need for recruitment in this specialty area, physicians in this specialty can recruit easily, have good connections with universities, and are highly connected. Due to these factors the committee rated this specialty a priority level 2B.

Pediatrics

Based on current pediatric patient wait times (2 to 3 weeks) and the prevalence of family practice physicians in Whatcom County that see a large number of children in their practice, the committee felt that there is no need to recruit for pediatricians at this time.

Primary Care

This specialty indicates a wide range between phase one (population analysis) and phase two (productivity analysis). In order to understand this difference, regional practice patterns verses national practice patterns must be understood. Phase two indicates that

not all primary care physicians have the same practice philosophy. The MGMA data reflects national practices; practice styles differ across regions. Many primary care physicians are office doctors that tend to practice primarily from their office.

Most Whatcom county physician practice, full spectrum family medicine; they work in hospital and nursing homes, admit patients, deliver babies, make home visits and are on call. About 35 percent to 40 percent of primary physician's time is spent in the care of children. All family physician's care for children, as do pediatricians, and none of the general internists care for children.

Psychiatry

This specialty is identified as a significant need in the community. The goal of the committee is to establish relationships with physicians practicing in this specialty before rating this specialty as a high priority.

Vascular Surgery

The committee felt that more information was needed about this specialty. General vascular surgery need was difficult to establish as other specialties provide some vascular procedures and acute care was difficult to separate from vascular cosmetic care. This specialty was identified as a priority 1B due to the need of additional information need but not necessarily due to a recruitment priority.

WAHA Recommended Priorities

This final list identifies the most significant priorities as Level One with sub categories of A (most significant) and B. Level Two priorities must be reviewed as a secondary need to Level One priorities. Also noted is the average wait time for a new patient to get an appointment in that specialty.

Level One

1A. Primary Care (Family Practice /Internal Medicine) – 2-3 weeks

1A. OB/GYN – 2-3 weeks

1B. Vascular Surgery – data not available

Level Two

2A. Nephrology – 2-3 weeks

2A. Orthopedics – 2-3 weeks

2A. Urology – data not available

2A. Psychiatry – 2-3 weeks

2B. Otolaryngology- data not available

2B. Infectious Disease – 5-7 days

2B. Ophthalmology – 5-7 days

2B. Physiatry – 6-8 weeks

2B. Rheumatology – 2-3 weeks

Print Survey Results

A confidential print survey was mailed to 377 Whatcom County physicians; there were total 144 responses. Due to the low response rate of 38% most of the quantitative responses are not statistically accurate. Therefore the scope of the results of this survey will focus on the pertinent qualitative aspects.

Question: Other than the issue of physician supply, from your experience, what factors contribute to difficulties in patients accessing medical services in Whatcom County?

Lack of Insurance

- Lack of adequate insurance
- Lack of health insurance
- Lack of health insurance
- Lack of insurance
- Coverage for younger people
- Lack of insurance coverage
- Insurance
- Lack of insurance coverage
- Lack of basic health. Low insurance.
- Not insured, under insured
- Lack of insurance coverage

Other Insurance Issues

- No primary care for Medicare patients
- Insurance requests, preauthorization.
- Insurance coverage from Medicaid and Medicare to private insurance limits
- Medicare. Medicaid.
- Expensive health insurance – Poor payers (DSHS, Molina) – Unable to refer DSHS/Molina patients to specialists
- State funded care patients have limited access (DSHS, Molina, Medicaid, & Medicare)
- Insurance constraints
- Insurance issues
- Physicians not seeing Medicare. Insurance not having providers in all specialties.
- Restrictions based on insurance (limited providers for Medicare, DSHS)
- Insurances
- Matching a patient's insurance with a provider who will accept that Insurance (esp DSHS/Molina/Medicare)
- Insurance issues – Medicare; Molina; DSHS
- Poor Medicare/Medicaid reimbursement, lack of insurance
- Insurance type or lack thereof
- Type of insurance
- Insurance coverage
- Insurance coverage
- Insurance coverage particularly Molina & Medicare

- Only the usual availability & insurance.

Reimbursement Issues

- Poor Medicare/DSHS reimbursement
- Inadequate reimbursement by Medicaid & Medicare
- Reimbursement from DSHS, Molina
- Insurance/payment issues
- Poor physician reimbursement
- Lack of reimbursement for needed services
- Poor reimbursement
- Poor primary care reimbursement, especially Medicare/Medicaid
- Poor compensation from Medicare & Medicaid
- Poor reimbursement
- Low reimbursement for uninsured
- Reimbursement issues
- Funding – eg low rates of reimbursement from Medicare/Medicaid
- Medicare reimbursement
- Poor reimbursement from Medicare & Medicaid.
- Low reimbursement rates for physician care
- Poor Medicare & Medicaid reimbursement. I am closed to Medicare & Medicaid except obstetrical patients.
- Medicare reimbursement
- Poor reimbursement causes offices to not take certain insurances
- Poor Medicare/Medicaid reimbursement
- Reimbursement
- Medicare & Medicaid reimbursement too low to allow me to see those patients

Other Responses

- Payor status of patient
- Medicare/Medicaid/private insurance pay level. Malpractice costs.
- Poor reimbursement & high cost of practice & high cost of living here
- Lack of finances/insurance
- Lack of mental health services; many physicians refuse to see under-or un-insured
- Need a “pain clinic” to manage chronic pain. Patient’s medication/ty.
- We sorely need better funding for uninsured medical, mental-health, and chemical dependency patients. *We need supervised housing options for patients with mental-health and chemical dependency issues
- Hospital requires board certification
- Some specialties (i.e., Derm) do not accept DSHS
- Managed care plans. Expense of care & sp. prescription drugs. “Monopolized group” → such as all pediatricians are @ Madrona
- Declining reimbursement. Increasing overhead, particularly malpractice insurance.
- Fragmented medical community, 2) Referral patterns don’t change

- In regards to ORTHOPEDICS the St. Joes. Admin. Decision to start their own orthopedic group will make it impossible for the other ortho groups to recruit new docs into their practice
- Severely limited access to primary & specialty care for Medicaid & Medicare, most especially for psychiatry
- Availability of PCP to Medicare prs who aren't elderly. Few accepting DSHS (sic).
- Not enough Dr care for DSHS, Medicare. Pts should be able to enter health care via naturopaths, clino +
- Low income, ↑ medical liability, low pt. compliance
- Insurance, awareness of need, transportation
- Cost
- Money
- Cost of medical care. Patients not insured.
- Physicians not accepting new Medicare patients.
- Medicare/Medicaid status & some other insurances which “low-ball” Physicians
- Misaligned financial incentives
- Limited Macr Access
- Payment plans, 2) Unrealistic expectations – patient wants to be seen for minor problems, 3) Overuse of medical resources
- Insurance coverage is discriminatory – Medicaid, Medicare w/o psychiatry
- \$, Lack of employer provided healthcare
- Comprehensive pain resources, i.e., pain psychology. Assessment of bio/psych/social issues to pain.
- Few 1° doctors see Medicare, 2) Hospital coverage is poor
- Keeping appointments. Chronic medical problem, expensive med & Tx. Pain Tx (chronic), Ψ care.
- Insurance wrangling, doctors not accepting insurance contracts & insurances not allowing any willing provider
- Lack of insurance. Lack of physicians taking Medicare.
- Limited services for low fee patients
- No one wants to pay the bill – not patients, not gov't, not insurance
- Lack of insurance. Medicare/Medicaid HMO hassles!!!
- I work part time at a community health center. I see three primary obstacles to accessing services: 1) Lack of money, so that patients have to choose between recommended medical care (referrals/imaging/labs/medications) even if discounted, and other expenses (rent, food, etc.), 2) practices refusing to accept Medicaid and/or Medicare, and 3) the patchwork of health plan participation, so that our patients get referred out of county for services that are otherwise available in county but the specialists are not participating providers.
- Reimbursement. Night call issues.
- Providers not accepting Medicare/Medicaid
- Uninsured/underinsured status – Lack of ortho trauma specialist to help generalists
- Some Drs demand high payments up front from Medicare & underinsured pts.

- No primary care “home”. Lack of self-planning for medical care.
- Cost of mandated benefits to both provider and patient. Should have a less expensive insurance plan available with fewer benefits. Also medical liability/tort reform ↓ acceptance of government insurance
- ER is used as outpt clinic, leaving true emergencies & difficulty to access Care
- Can’t afford medication or treatments
- ↓ access for DSHS & Medicare
- Many primary care offices will not accept Medicare patients
- Primary care docs refusing to see Medicare, Medicaid patients. Rising overhead with declining reimbursement.
- Affordability – no insurance. Specialty consultants not taking Molina.
- Insurance coverage and contracting. Rates paid by Medicare and Medicaid plans, severely limit patient access to care.
- Employers cutting back on insurance coverage or offering no coverage.
- Several specialties either don’t take Molina (sleep med, general surgery, ortho, dermatology) or only take a very limited # of urology, rheumatology, endocrine, psychiatry
- Not many practices accepting new medicare pt
- None or limited health insurance including high deductible insurance and state funded insurance
- Insurance coverage, lack thereof, coordination of care, project access
- Insurance – lack of access due to Medicare/Medicaid, poor reimbursement and lack of specialty care for patients with their insurance

Conclusions for Future Surveys

What we learned:

- Office managers respond more easily than physicians
- Web-based survey was convenient and easy to use by office personnel
- Goodwill was created through incentives and recognitions with practices – a benefit for future participation
- Physician response for paper survey was too low to allow for statistical validity. Therefore, the physician response was used qualitatively.
- Consistently following up with practice managers enabled a significant response rate.
- Engagement and input with the WAHA committees is essential. Local industry knowledge of these professionals was outstanding.
- Redesign question set so that survey is based solely on information needed.