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Original research

Physicians' early perspectives on Oregon's Coordinated Care Organizations

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ABSTRACT

Background: Through development of Coordinated Care Organizations (CCOs), Oregon's version of the Accountable Care Organization (ACO) for Medicaid beneficiaries, Oregon is redesigning the healthcare system delivering care to some of its most vulnerable citizens. While clinicians are central to healthcare transformation, little is known about the impact on their role. The aim of this study was to understand the current and perceived effect CCO-related changes have on Oregon physicians' professional and personal lives.

Methods: This qualitative observational study involved semi-structured interviews, conducted between March and October, 2013, of twenty-two purposively selected physicians who varied in years of practice, gender, employment status, specialty, and geographic location from three different CCOs. A grounded theory approach was used to analyze data.

Results: Physicians expressed uncertainty and ambiguity about the CCO model, reporting minor financial changes in the first year, but anticipating future reimbursement changes; new team-based care roles and responsibilities, accountability for quality incentive measures; and effects of CCO implementation on their personal lives. To meet CCO model changes and requirements, physicians requested collegial networking, team-based care training, and data system and information technology support for undergoing health system transformation.

Conclusions: Although perhaps not immediate, healthcare reform can have a real and perceived impact on physicians' professional and personal lives.

Implications: Attention to the impact of healthcare reform on physicians' personal and professional lives is important to ensure strategies are implemented to maintain a viable workforce, professional satisfaction, financial sustainability, and quality of care.

1. Introduction

Healthcare reform depends on physician engagement in practice redesign. Changes that practices make to achieve the "Triple Aim" [1], such as moving toward team-based care models, have implications for physicians working in these settings. System modifications perceived to negatively affect care quality [2] and physician–patient relationships [2,3] may reduce physician satisfaction, impair physician well-being, and lead to burnout [4–9] irrespective of physicians' individual traits [5,9]. Understanding characteristics of practice change most affecting physicians can assist in developing interventions to lessen those effects.

Currently, Oregon is implementing Coordinated Care Organizations (CCOs), a version of Accountable Care Organizations (ACOs) with characteristics of previous Managed Care Organizations (MCOs) [10–13] Started in August 2012 and requiring a Medicaid waiver [14], CCOs were signed into law as a way to change Medicaid healthcare delivery through local governance at the community level; integrate physical, behavioral, and dental healthcare; establish a global budget that grows at a fixed rate; and give CCOs flexibility to cover non-traditional healthcare costs and accountability for quality and cost [10–13,15] The model is intended to expand to other payers [16] and successful implementation depends on community engagement of hospitals, health systems, payers, community members, and physicians. Currently, 95% of Medicaid beneficiaries and 55% of dual eligibles in Oregon receive healthcare through the CCO model, and 74% of physicians participate [17].

While research suggests that physicians are affected during periods of reform [9,18,19] there is little information to explain what aspects of health system change are most influential, and how change affects physicians, personally and professionally. To answer these questions, we conducted 22 semi-structured interviews with physicians of different specialties across Oregon.

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2. Methods

2.1. Sample

We purposively selected 22 physicians to maximize variation on the following attributes: (1) participation in one of three CCOs differing in region of state and business model employed, (2) gender, (3) specialization, (4) geographic location of practice (urban, rural), and (5) ownership of practice (private, health system employed). See Table 1 for details on the study sample. We contacted 38 physicians by email, and 22 agreed to participate. All physicians interviewed had previous experience caring for Medicaid patients.

2.2. Data collection

The Oregon Health & Science University Institutional Review Board approved the study protocol. Between March and October 2013, we conducted semi-structured interviews with physicians using an iterative approach. A small number of participants were selected and interviewed, their interviews analyzed, and emerging findings were used to select subsequent participants. This was done to ensure study participants varied on the most important attributes, and to allow our team to monitor when saturation was reached. Saturation is the point at which no new findings emerge from the data collection and analysis process. Semi-structured interviews, following a guide (Appendix 1), were conducted face-to-face, approximately one hour long and were audio-recorded. After analyzing data from 11 interviews, we focused our next round of data collection on physicians who were earlier in their careers, and worked in independent, rural practices, as physicians with these attributes had differing views which we needed to explore. Additionally, we made minor modifications to the interview guide to include deeper probes about health system change, team-based care, and drivers of professional satisfaction.

Interviews were professionally transcribed, de-identified and entered into Atlas.ti (Version 7.0, Atlas.ti Scientific Software Development GmbH, Berlin, Germany).

2.3. Analysis

We used a grounded theory approach to analyze data, following the five-step analysis process outlined by Miller and Crabtree [20] and an immersion–crystallization approach [21]. In the first immersion cycle, we analyzed segments relevant to physicians' involvement and experiences with CCO efforts, identified key themes (crystallization) and developed a coding structure. Using the coding structure, team members analyzed the remaining interviews, meeting regularly to discuss new findings, refine the coding structure, and resolve analytical disagreements. We engaged in a second immersion–crystallization cycle to identify crosscutting patterns. During a third analysis cycle, we examined how physician characteristics, such as specialty, career stage, and CCO involvement, might influence participants' experiences. We shared preliminary findings with a Steering Committee comprised of three physicians, a senior qualitative researcher, and research analyst, refining our findings based on group feedback.

3. Results

Physicians were members of three CCOs, varying in size, geographic location, and organizational structure. CCO1 ($n=5$) is the largest, located in a metropolitan area, and is a collaborative of hospitals, health systems, and insurers aligning efforts to serve the larger CCO population. CCO2 ($n=7$) includes an urban area surrounded by rural and agricultural communities governed through joint management agreements between a non-profit insurer, provider community coalition and hospital. CCO3 ($n=10$) includes urban and rural areas, created by a health plan and for-profit independent practice association. Physician characteristics are summarized in Table 1. Eleven (50%) physicians were female, 14 (63.6%) specialized in primary care, 5 (22.7%) practiced in rural areas, 10 (45.5%) were health system employed, and 10 (45.5%) described themselves as involved in CCO planning.

3.1. CCO model engagement

Some physicians reported involvement in early CCO efforts, yet felt there was ambiguity regarding direction and impact of the CCO, largely because CCOs were in early stages of development: "*It feels like everyone is still in the, we're trying to get this started phase… So I don't have the appreciation that this is fully functional*" [CCO3, Physician 15, Specialist]. Physicians wanted to be informed of CCO developments. They felt that learning from others could help them better navigate the change process: "*I'd like for somebody to tell me what the endgame looks like so I could start developing the pathway there… bringing people from other communities together more would be helpful…*" [CCO3, Physician 18, Specialist].

Factors shaping physician involvement and knowledge about

Table 1
Physician participant characteristics.

	Gender		Employment Type			Career Stage		Geographic Type		CCO Involvement[a]	
	Male	Female	Health System	Private Practice	CCO Employed	< 5 years	> 5 years	Urban–Semi-urban	Rural	Yes	No
CCO1 ($n=5$)											
PCP	2	3	4		1	2	3	5		3	2
Specialist											
CCO2 ($n=7$)											
PCP	3	2	1	4		4	1	1	4	1	4
Specialist	1	1		1	1	2		2		1	1
CCO3 ($n=10$)											
PCP	4		2	1	1	1	3	4		4	
Specialist	1	5	3	3		3	3	5	1	2	4
Total	11	11	10	9	3	12	10	17	5	11	11

PCP: Primary care provider.

[a] CCO involvement includes board, committee membership, and CCO employment.