



Access to US primary care physicians for new patients concerned about smoking or weight



Sarah E. Tinkler^a, Rajiv L. Sharma^{a,*}, Raven R.H. Susu-Mago^a, Sudeshna Pal^a, Miron Stano^b

^a Department of Economics, Portland State University, Portland, OR, United States

^b Department of Economics, Oakland University, Rochester, MI, United States

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ABSTRACT

Tobacco smoking and obesity are leading causes of preventable morbidity and mortality in the US, and primary care physicians are the main source of preventive care. However, it is not known whether access for new patients is affected by an expression of interest in preventive care. In a 2015 audit, we called US primary care physicians' offices to request appointment information regarding new patient physicals for simulated patients. Simulated patients were differentiated by smoking concerns ($N = 907$), weight concerns ($N = 867$), or no health concerns ("healthy" patients; $N = 3561$). Additionally, patient profiles varied by race/ethnicity, sex, and insurance type. We also examined whether access differed in states that expanded Medicaid under the Affordable Care Act. We found that physicians' offices were no more likely to offer appointments to patients with smoking concerns than to healthy patients (54% vs. 55%; p -value = 0.56), and patients with smoking concerns were offered fewer appointments than patients with weight concerns (54% vs. 62%, p -value < 0.01). In analyses adjusted for covariates, smoking concerns did not improve appointment offers for any patient group, and reduced Medicare patients' offers in Medicaid expansion states by 9 percentage points relative to healthy patients (95% CI: -16, -2). Health concerns did not statistically significantly affect waits-to-appointment. Our results suggest that patients with smoking concerns are no more likely to be offered new patient appointments than those with no health concerns. The greater likelihood of appointment offers for some patients with weight concerns is encouraging for obesity prevention and management.

1. Introduction

In the United States, cigarette smoking accounts for over 480,000 deaths and more than \$300 billion in direct medical costs and lost productivity annually, making it the leading cause of preventable morbidity and mortality (Centers for Disease Control and Prevention (CDC), 2016). Tobacco smoking cessation interventions have a US Preventive Services Task Force (USPSTF) grade of A, which denotes a "high certainty that the net benefit is substantial" (USPSTF, 2015). Over two-thirds of American adults are overweight or obese (National Center for Health Statistics (NCHS), 2017), and the USPSTF assigns obesity screening and management a grade of B, denoting a "high certainty of moderate net benefit or moderate certainty of moderate to substantial net benefit" (USPSTF, 2016). Additionally, the National Academy of Medicine recommends tobacco cessation, physical activity, and nutrition counselling for chronic disease prevention (Dzau et al., 2017). Despite this, high-value preventive care, especially for tobacco cessation counselling, remains underprovided (Barnett et al., 2017).

Primary care physicians are the main source of preventive care in

the US, including clinically- and cost-effective smoking cessation interventions (e.g., Kotz et al., 2014; Starfield et al., 2005). Policy actions, such as Medicaid expansion under the Affordable Care Act (ACA), seek to improve access to both primary and preventive care (Davis et al., 2011). Currently, it is unknown whether access for new primary care patients is affected by an indication of potential interest in preventive care. To address this question, we conducted a national audit (simulated patient study) of primary care physicians' offices.

Audits have been used to examine access and disparities in many markets (e.g., Bertrand and Mullainathan, 2004; Ge et al., 2016). By experimentally controlling for patient characteristics, health care audits avoid the major limitations of other methodologies. These include selection and social desirability biases in surveys, and the inability to fully control for differences in health and treatment preferences in utilization studies (Institute of Medicine (IOM), 2002). Among audits of access for patients with specific health needs, few include a healthy control group. Of those that do, a Canadian audit found that patients with diabetes and low back pain were more likely to be offered new patient appointments than patients expressing no health concerns (Olah et al., 2013). In

* Corresponding author at: Department of Economics, PO Box 751, Portland State University, Portland, OR 97207, United States.
E-mail address: sharmar@pdx.edu (R.L. Sharma).

contrast, a US audit found that offers to patients with hypertension did not differ substantially from offers to patients with no health concerns (Rhodes et al., 2014). This study examines whether appointment offers to new US primary care patients who mention concerns about smoking or weight differ from offers to patients with no health concerns (“healthy” patients).

2. Methods

Data are from an annual, nationwide audit (Sharma et al., 2015; Sharma et al., 2018; Tinkler et al., 2017). Since 2013, trained research assistants (RAs) have called primary care physicians' offices on behalf of a purported aunt or uncle requesting information about the earliest available new patient appointment for a physical exam. In the ongoing study, RAs do not mention health but, if asked, state that the patient is “generally healthy but it is time for a checkup”. Simulated patients differ by race/ethnicity, sex, and insurance type (Medicaid, Medicare, private insurance through a job, and self-pay/uninsured). Race/ethnicity is implied by characteristically black, white, and Hispanic names developed from the literature on racially and ethnically distinctive first and last names (Bertrand and Mullainathan, 2004; Lavender, 1988; Word and Perkins, 1996). The ongoing study utilizes 72 healthy patient profiles (3 female and 3 male names for each of the 3 racial/ethnic groups, and 4 insurance types). In 2015, profiles with smoking or weight concerns were also used.

2.1. Conceptual framework

The IOM (2002) classifies differences in healthcare as arising from (i) patient preferences or clinical appropriateness and need; (ii) health system related factors; and (iii) discrimination. Only differences due to (ii) and (iii) are regarded as disparities. In our ongoing study, patients are healthy, and differences in access represent disparities under the IOM framework. The comparisons between healthy patients and those with smoking or weight concerns in this paper assess how needs and preferences affect access to primary care physicians.

Disparities may also arise due to financial considerations. Sloan et al. (1978) postulate that physicians are less likely to accept patients who generate less revenue and impose higher costs. Revenue depends on reimbursement and coverage, and factors such as patient complexity contribute to costs. Reimbursement varies by insurance type, and Medicaid patients, in particular, face limited access due to low physician payments (Decker, 2012; Sharma et al., 2018). Post-ACA federal regulations mandate coverage of some preventive care for smoking (4 counselling sessions, 90 days of medication, and up to two quit attempts per year) for Medicaid expansion, Medicare, and non-grandfathered private insurance plans. Under non-expansion Medicaid, coverage varies greatly at the state level (American Lung Association, 2018; Singleterry et al., 2014). Interventions for obesity include counselling, medications, and bariatric surgery. In 2014, Medicaid programs in 14 states covered obesity drugs, 47 states (and Washington, DC) covered bariatric surgery under some circumstances, and 28 states covered some nutritional counselling (Petrin et al., 2014). Post-ACA federal regulations require obesity screening and management coverage by non-grandfathered private health plans (Kaiser Family Foundation, 2015). Medicare covers bariatric surgery for qualified patients, excludes coverage of pharmaceuticals for obesity, and covers obesity counselling under restrictive rules with low reimbursement (Andrews, 2015).

Following Medicaid expansion, Medicaid enrollment increased more rapidly in expansion states than in non-expansion states (Rudowitz et al., 2015). Medicaid policy creates spillover and substitution effects for patients with other insurance coverage (e.g., Sharma et al., 2018; Antonisse, et al., 2017). For example, increased demand from newly insured patients may exacerbate physician shortages. On the other hand, increased emphasis on preventive care under expanded Medicaid may spill over into prioritization of all

patients with preventive care needs. Therefore, some of our analyses examine expansion states separately from non-expansion states.

2.2. Physician sample

Call lists each year comprise a national, random, unstratified sample from the latest American Medical Association's Physician Masterfile. The Physician Masterfile is a comprehensive listing of licensed US physicians and is frequently used in analyses of the US healthcare system (Association of American Medical Colleges, 2016; Donelan et al., 2013). We restrict our lists to physicians with primary specialties in family medicine, general preventive medicine, internal medicine, general practice, and urgent care. Family medicine and internal medicine comprise 95% of the samples in nearly equal parts.

The ongoing study employs an overlapping cohorts design (i.e., the 2013 physician cohort was assessed in 2013 and 2014; the 2014 cohort was assessed in 2014 and 2015, and so on). The new list each year ensures that our sample remains representative of US primary care physicians. The overlap allows us to distinguish changes in access over time from any potentially confounding effects of the changing sample. Analysis of 2014–2016 data found no statistically significant differences in appointment availability between any two physician cohorts called in the same year. Therefore, the healthy group data utilized in this paper combines the two physician cohorts audited in 2015. Appendix A describes how patient profiles were assigned to physicians, as well as how physician eligibility and reachability were determined. Like many earlier healthcare audits, the response rate was 100% of reachable and eligible physicians. Our physician sample (mean age = 54, female = 35%, osteopathic physicians = 12%) is demographically similar to active US physicians (Young et al., 2014). Calls were completed between July 28th and December 15th of 2015.

2.3. Call protocol

Using a detailed script that has been described previously, RAs claim to be calling for an aunt or uncle who has moved to the physician's area and is seeking a new patient physical exam (Sharma et al., 2015). This call protocol makes it plausible that the RAs lack detailed information about prospective patients and permits them to represent patients with demographic characteristics different from their own. The smoking/weight scripts suggest a possible interest in preventive care. They begin:

My aunt (uncle) NAME has recently moved to your area, she (he) is worried about her (his) smoking (weight) and I am helping her (him) find a doctor there. Could you please tell me when the earliest appointment for a physical exam is available with Dr. NAME?

Physicians' offices rarely (< 1%) requested specifics about smoking or weight but, if asked, RAs stated that the patient consumed “half a pack a day,” or weighed an amount consistent with a body mass index of 35 for a man or woman of average US height. The patients' general insurance type was requested by 34% of physicians' offices, while 7% requested detailed insurance information (insurance carrier, policy number, etc.). If a physician's office did not request insurance information, RAs asked whether the physician accepted the patient's insurance type.

2.4. Protection of human subjects

The deception involved in simulated patient studies raises ethical concerns. We mitigate risks to physicians, their office staff, and their patients by instructing RAs to request information but not to make actual appointments. We minimize the burden on physicians' offices by determining reachability, eligibility, and appointment availability in a single call. Random assignment of each physician to a single patient profile protects individual physicians' offices against perceptions of bias

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