Will Commercial Managed Care Patients Accept Residents as Their Primary Care Providers?

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We conducted a telephone survey of patients in a university-based medical practice to determine if there was a difference across payer class in patients' willingness to have supervised housestaff physicians function as their primary care providers. Overall, commercial managed care patients were more likely to object to seeing housestaff physicians than were Medicaid or Medicare patients (50% vs 32% or 23%, respectively). However, prior outpatient care by a resident physician significantly increased patient willingness to be cared for by a resident. This effect of prior care by a resident was noted in the managed care as well as the Medicaid and Medicare populations. Although there may have been self-selection, our data demonstrate that a significant proportion of managed care patients who have had residents as their primary care providers are amenable to continuing this practice.

KEY WORDS: managed care; patient preference; residents, as primary care providers.

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Traditionally, internal medicine residency training has focused on the inpatient wards. However, in the past decade emphasis on medical training in ambulatory care has increased. The increasing need for high-quality outpatient educational experience for residents, combined with the emergence of managed care organizations as the dominant insurer in many health markets, makes it important for residents to serve as primary care providers (PCPs) for managed care patients from both a practical and educational perspective. However, many managed care organizations have been reluctant to establish contracts with academic groups. The primary reasons are concerns about maintaining managerial control, efficiency, and patient satisfaction.¹⁻³ Importantly, administrators of managed care organizations have questioned whether their patients would be amenable to residents' participation in their care.

We designed this study to determine if patients insured by commercial managed care plans are willing to have housestaff function as their (supervised) PCPs, and whether prior experience with a resident in this role would affect their decision. Medicaid and Medicare pa-

tients, who are not under managed care and have traditionally received much of their outpatient care at teaching practices, were compared with commercial managed care patients. As a secondary end point, we assessed patient satisfaction as a function of payer status and prior experience with housestaff PCPs.

METHODS

The New York Hospital-Cornell Internal Medicine Associates is an urban, university-based medical practice staffed by housestaff and attending physicians. Of the 22 attending physicians, 17 work at the practice full-time; the 120 residents and interns constitute the hospital's internal medicine residency program. Patients come to the practice by a variety of means including self-referral, patient-referral, physician-referral, or by selecting the practice from the list of their managed care organization's preferred providers. The payer status of the patient population consists of approximately 35% Medicaid, 35% Medicare, and 30% commercial insurance; attending physicians and housestaff see patients from all payer groups. More than 80% of the commercially insured patients belong to a managed care plan.

On entering the practice, patients are assigned to an attending physician, an intern, or a resident as their primary physician and see the same individual on subsequent follow-up visits. Patients may request to be assigned to a specific doctor, but if they do not, they are assigned to the one with the next available appointment. The patients assigned to housestaff are informed of their physician-in-training status by the scheduling personnel. Approximately 15% to 25% of new patients request to see only an attending physician when making their initial appointment, while a smaller proportion request to see only housestaff.

Interns and residents present all cases to the attending physicians, who supervise all care. Attending physicians routinely see all of the interns' patients briefly, as well as the residents' new patients and any patients who present complex cases. The level of supervision is the same for all insurance groups.

A randomized list of patients sorted by payer status was generated using the practice's computerized database. Three attempts were made to reach each participant by telephone, with callbacks scheduled when necessary. A survey script included the exact wording of the questions as well as explanation of the survey and all relevant terms, such as the "attending physician," "intern," and "resident." The supervision of residents and interns was also explained, as described above. Patients whose PCP was an attending physician were defined as "attending

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patients," while those with a resident or intern as their PCP were defined as "housestaff patients."

Patients were assured that their answers were strictly confidential and would not be shared with their personal physician. Global satisfaction questions were assessed using a 5-point Likert-type scale. Respondents were also asked whether they would object to having a resident or intern as their PCP.

Responses to satisfaction questions were calculated as means. The responses to the "objection to housestaff" question were calculated as proportions. Multiple *z* tests with Bonferroni correction were used to compare the proportions between the three payer subgroups.

RESULTS

We successfully reached 160 patients from a randomly generated list of 273; 156 (98%) of these 160 patients agreed to participate in the survey. As shown in Table 1, Medicaid and commercially insured managed care patients were younger than Medicare patients. Our sample was overwhelmingly female, reflecting the patient population of the clinic.

Overall satisfaction with care did not differ significantly by payer group, although patients insured by managed care organizations showed a trend toward less satisfaction with their care than did Medicare or Medicaid patients (Table 1). There was no significant difference in reported satisfaction of attending patients and housestaff patients, even when adjusted for payer status. Patients insured by managed care organizations were more likely to report that they understood the differences between housestaff and attending physicians, and that they knew the training level of their primary physician.

As a group, 20% of Medicaid patients, 32% of Medicare patients, and 50% of commercial managed care patients reported they would object to seeing an intern or resident rather than an attending physician as their PCP. The difference between managed care and Medicaid patients was statistically significant (adjusted *p* < .05); that

between managed care and Medicare patients was not (adjusted *p* = .06).

Respondents were separated into attending patients and housestaff patients. Attending patients were more likely than the housestaff patients to object to a housestaff PCP (*p* < .05). This relation was noted across all payer classes.

Nevertheless, only 32% of commercially insured patients who had a housestaff PCP objected to seeing a housestaff PCP, while 61% of these patients who had an attending PCP objected to seeing a housestaff physician in that capacity (Fig. 1). Likewise, whereas 6% of Medicaid patients who were housestaff patients objected to having a housestaff PCP, fully 50% of Medicaid attending patients objected to having a housestaff PCP (*p* < .05). A similar trend was seen for the Medicare patients.

DISCUSSION

The high level of global satisfaction expressed by our patients is similar to that reported by other studies.^{4,5} However, the specific question of managed care patients' satisfaction and willingness to have housestaff physicians in the outpatient setting has not been previously reported.

Studies have demonstrated that patients with residents and patients with attending physicians have similar satisfaction rates.^{5,6} Another study showed that private patients are willing to accept a limited delegation of their care to residents without direct faculty supervision.⁷ Their willingness decreased in correlation with the responsibility inherent in each task; for example, 93% of the patients were willing to allow a resident to take their history, but only 30% would allow a resident to prescribe medication or treatment.

These studies, however, were either performed at small practices or had limited response rates. Our study sampled patients from a large teaching practice in which housestaff and attending physicians care for patients from all payer groups in the same setting.

Table 1. Patient Demographics and Responses by Payer Category

Demographics and Responses	Medicaid (<i>n</i> = 49)	Medicare (<i>n</i> = 55)	Managed Care (<i>n</i> = 52)
Age, years ± SD	53 ± 9	74 ± 13	49 ± 17
Female, %	92	69	87
Satisfaction with care*	4.5	4.8	4.2
Understand the terms "resident" and "attending," %	53	36	58
Know training level, %	41	33	60†
Unwilling to see a resident, %	20	32	50‡

*Differences were not statistically significant.

†*p* < .05 for comparison with Medicare group.

‡*p* < .05 for comparison with Medicare group.

FIGURE 1. Proportion of patients objecting to having a housestaff physician serve as their primary care provider.

Patients insured by commercial managed care plans were significantly more reluctant to have an intern or resident as their PCP. Prior experience with a housestaff PCP, however, increased their willingness to be cared for by a housestaff PCP. Only 32% of those patients who had seen a resident or intern previously indicated that they would object to having one as their PCP.

Some managed care organizations have expressed concern about patient satisfaction when residents provide health care for their members. However, our study demonstrates similar satisfaction ratings for the attending physicians' and residents' patients within each payer class. Further studies involving a larger sample of patients and with satisfaction as a primary end point would be helpful. It would also be informative to examine the effect of degree of illness, duration of doctor-patient relationship, and number of years of training on the satisfaction of patients of attending physicians and patients of housestaff.

A weakness of this study was that it took place at a single institution and may not be representative of experience elsewhere. There was a selection bias, as the housestaff patients may have been more willing to see these

physicians-in-training at the outset. This self-selection is necessary, however, as patients must be given the choice of whether they feel comfortable seeing a housestaff PCP. Another bias inherent to a cross-sectional study such as this is patient migration, as patients unhappy or uncomfortable with housestaff physicians may have moved to the attending physician group. This could have artificially decreased satisfaction in the attending group relative to the housestaff group. In addition, a global satisfaction scale is not optimal, and future studies will include more comprehensive measures of patient satisfaction.

Our data suggest that many patients are willing to have housestaff participate in their health care in an integrated, well-supervised, group practice. As more of the insured population becomes enrolled in managed care organizations, these patients can provide a significant source of new patients for training programs.

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