

The Joys and Challenges of Caring for Older Adults by Primary Care Physicians: Results of Focus Groups in Western North Carolina

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Objectives: Primary care physicians (PCPs) are caring for a higher volume of older adults as our population ages. We elicited regional PCPs' feelings on the joys and challenges of caring for older adults in order to help design future interventions in primary care.

Methods: We conducted focus groups using a semi-structured interview guide with 20 PCPs from six practices in our 16-county region. Audio tapes were transcribed and de-identified; thematic analysis was performed. Authors reviewed transcripts to identify overarching themes, and reached consensus on themes and exemplary quotes.

Results: PCPs reported joys as: the interpersonal relationships, the patient stories; keeping patients independent; streamlining medications; and navigating patients through a complex medical system. Challenges were focused around the: medical complexity of patients; intensity of relationships with patients and their families; management of socioeconomic issues of care; short appointment times; and discomfort and concern with aspects of team-based care.

Conclusions: Redesigning primary care for seniors must enhance or maintain the joys while reducing the challenges. The team-based care model can accomplish this if concerns about losing contact with patients and trusting non-physician team members can be addressed. We will need to provide assistance to PCPs to gain competencies and comfort with team-based care.

Key words: Geriatrics, Primary Care, Provider Perceptions, Focus Groups, Qualitative Research

Introduction

Throughout the 21st Century, the average lifespan has continued to increase. Patients are living longer than ever before, and the growing geriatric population presents with unique challenges that physicians must meet. Studies have shown that the majority of these older patients seek care from primary care physicians rather than geriatricians.¹ With 21.4% of the population in Western North Carolina over the age of 65, the region boasts a much higher population of elderly citizens than the state average of 14.6%. It is estimated that by 2030, over one quarter (26.2%) of the population will be 65 or older.² As the population continues to age, primary care physicians in the region will need to be familiar with the types of challenges that geriatric patients can present, and how best to address them.

Primary care physicians (PCPs) report that caring for Medicare patients can be difficult. Adams et al. interviewed 20 PCPs and found that the medical complexity and chronicity of patients, personal and interpersonal challenges, and administrative burdens were the most common

issues surrounding delivery of care to this population.³ If patients presented with one or more of these problems, then the challenges were multiplied.

Another survey of 212 physicians in rural Florida reported a significant negative perception about the abilities of patients aged 85 years and older to: present as intelligent, informed patients; offer valuable information; learn new information; make informed decisions; reliably judge the quality and severity of their symptoms; make changes, even if provided information and emotional support; and improve their health.⁴ This suggests an ageist mentality among physicians that could be detrimental to providing quality care for patients, especially considering that rural patients have no other source of care than their local primary care provider.

In a study of the Generalist Physician Initiative to enhance the care of older people provided by PCPs, researchers found that physicians were more willing to ask about issues outside of the traditional medical model if they had access to a care coordinator/social worker on whom they could offload these challenging concerns.⁵ However, most physicians felt that due to time constraints and the complexity of their patients' issues, they were not able to fully embrace interdisciplinary practice and collaboration with outside agencies/services.⁵

Helton and Pathman surveyed residents in seven family medicine residency programs in North Carolina and found that although nearly all residents reported positive attitudes towards their elderly patients, only about two-thirds believed that older adults would compose a significant percentage of their patients in the future. They also noted that financial compensation for geriatric care is low.⁶

Multiple authors have proposed the restructuring of primary care to better serve older adults, including innovative care delivery models such as co-management, augmented primary care with new roles for office staff, and team-based care.⁷⁻¹¹ In one study, older patients reported that they would be interested in a team-based care model and believe it would improve their care.¹² Other improvement strategies place emphasis on altering internal resources such as the physical facility, using structured notes, and implementing block scheduling for patients. Enhancing community linkages to assist patients and families has also been suggested.⁷⁻¹¹ Sinsky et al. promote the phrase "joy in practice" to imply a fundamental redesign of the medical encounter to restore the healing relationship between physicians and patients.⁹

Considering the rapidly growing older population in our region and the need to better serve older adult patients of Western North Carolina, our organization, the Mountain Area Health Education Center (MAHEC), has an interest in eliciting physician perspectives on the joys and challenges of caring for older adults. Knowing these perceptions, we may be able to design interventions to enhance the joys of caring for older adults among PCPs, while improving care delivery and the experience for our patients.

Methods

We conducted focus groups with primary care physicians in MAHEC's service area, which consists of 16 counties across Western North Carolina.

Participants

The sample was purposive to maximize coverage of geography with the intent to find a mix of rural and urban, small and large, and residency and private practices. Via email, Dr. Landis (the principal investigator, PI) approached practitioners she knew might be likely to participate. Out of approximately 63 family medicine practices in the region, 20 providers (19 physicians, 1 mid-level provider) from six practices participated; five providers within these practices did not come to the focus groups. All practices contacted agreed to participate.

Eleven of the participants were women (55%) and the rest men [n = 9 (45%)]. All were Caucasian. They had been in practice ranging from 1 to 30 years, with half (n = 10) having been in practice five years or less. Thirteen providers (65%) were graduates of the family medicine residency program where the PI worked as an attending faculty. Of the six practices, two were independently-owned, two were hospital-owned, and two were affiliated with family medicine residency programs.

Focus Groups

Six focus groups were conducted, using a semi-structured interview guide, by the PI and a health educator who served as a note taker (ST). Both were experienced in conducting focus groups. Each focus group lasted 90 minutes and met in the providers' practices (n = 4) or in the PI's office (n = 2). Focus groups ranged in size from 1 to 9 providers. Focus groups were audio recorded with the verbal permission of the participants. Field notes were taken before, during and after each focus group. In two cases, medical students on clinical rotations with the physicians also attended the focus groups.

Semi-structured Interview Guide

The sessions included a brief introduction and six questions with follow-up probes and prompts as indicated. Questions were developed and refined by eliciting expert opinion from colleagues outside the focus groups participant pool. They included:

1. What aspects of primary care geriatrics do you find most satisfying?
2. What aspects of primary care geriatrics do you find most challenging?
3. What changes in terms of care delivery has your practice made to try to improve care for older adults?
4. I'm going to ask you about four common issues primary care providers see with their geriatric patients: screening and care for: a) falls, b) dementia and depression, c) urinary incontinence, and d) having advance care planning (ACP) conversations. Are you screening for these issues and having ACP conversations? In what situations - (as part of the Annual Wellness Visit only or are you prompted yearly to do this)? What are the challenges with the screenings and having the conversations around ACP?
5. Now that we have covered many of the challenges of caring for older adults in primary care, what are your suggestions for improving the quality of and the coordination of care here in Western North Carolina?
6. Are there other issues around care for older adults that we have not discussed?

Data Analysis

Audio tapes of focus groups were transcribed verbatim by either the note taker (ST) or a transcriptionist and de-identified. Thematic analysis was performed by a researcher unrelated to the provider participants (SG). The thematic categories were identified via multiple reviews of the transcripts using an inductive process. After debriefing with the PI, the thematic categories were refined and quotations recoded. The PI, the coder and the lead author reviewed the thematic categories and quotations independently to identify overarching themes, then met to discuss and reach consensus.

We report here on the themes identified in responses to questions 1 and 2 that focused on the joys and challenges of providing healthcare to older adults (see Table 1). Verbatim quotes are followed with the focus group and participant number, e.g., (4.1) means focus group #4 and participant #1 in that focus group.

Results

The overarching themes of joys and challenges are shown in Table 1.

Table 1. Themes of the Joys and Challenges

Joys	Positively impacting patients' lives
	Learning from patients
	Being involved with well, older patients
	Assisting with life transitions
	Helping families navigate the complex medical systems
	Being involved with multiple generations of a family
	Caring for very complex patients Polypharmacy Multiple specialists
Challenges	Dealing with family dynamics
	Dealing with patients' socio-economic limitations
	Dealing with limited, high quality community resources
	Dealing with limitations of the current health systems Time constraints Reimbursement structure Lack of resources to implement team-based care

Joys

Participants reported the most satisfying aspect of primary care geriatrics was being able to positively impact patients' lives. Several mentioned keeping patients independent and *"doing what they want to do."* [4.1]

Multiple providers listed discontinuing medications: *"It's always great when you can get someone to stop a medication that they don't need any more and they feel better."* (5.1)

Participants also reported enjoying the meaningful relationships formed with their older adult patients:

I really enjoy the relationship, getting to know their stories. Because when I feel like I understand their stories, you know what kind of environment they live in, we have a good relationship and it fosters trust... [2.4]

Participants reported enjoying learning from their patients:

They're just such a unique population and they bring such wisdom to the table.[6.1]
That's my favorite thing, hearing their life story. Their experiences are very different for the most part from what I've experienced, so it's opened my eyes in a way that I might not have thought about. [2.8]

One participant delighted in being a part of the life of a well, older adult patient:

I love the independent geriatric patients, the ones still in their garden, that just go, go, go. They just don't sit down and wait for things to deteriorate. Not everyone is lucky enough to have health to allow them to do that. But I love the ones that are. [2.7]

Others found it rewarding to assist patients with transitions through the stages of life. Some mentioned gaining satisfaction in seeing how patients navigated the aging process and some of the associated changes in independence. Being a part of end-of-life care was mentioned as a positive experience, *"when [it] goes well."* [5.2]

Providers also found satisfaction in helping patients and families navigate through a complex medical system:

Hospital follow ups. If they've been on a specialist service, they come to us for the hospital follow up and they have no idea what their medications [are] – they have a medication list, and you see all these lines drawn through it, question marks, and circles. The daughter or the son is just completely overwhelmed and doesn't know what's going on...I will help them navigate that, iron out the details...And I feel that gives them a lot of relief, even if you aren't doing anything medically per se. [3.4]

One participant relished being able to care for multiple generations of the same family, saying “that’s the ideal” as a family practitioner. [1.1] Others appreciated seeing their patients with family members and understanding them “in the context of their greater family.” [1.3]

Challenges

Practitioners cited many obstacles to providing geriatric care. When asked what they found most challenging, many reported the medical complexity of older adult patients—“They tend to have so many problems at that point that you’re just trying to balance what their medicines are with guidelines or goals.” [4.1] Frustration with polypharmacy and multiple specialist prescribers was frequently mentioned:

There are multiple physicians involved, and the medications get changed, and the patient had no idea. Maybe I get a note, or I don't get a note, or if I get a phone call from the other doctor that changed the med and it's not documented... [5.1]

Another common theme was difficulties in dealing not only with the patient, but with his/her family as well. Providers also recalled frustrations with families unable to make what the providers felt to be appropriate medical decisions for the patient’s life stage:

I have a guy who's 90-something at the nursing home; he's actively declining, getting combative. His daughter told us the other day, “Well, I'm just not ready for Daddy to go.”...That's why we're getting all these ridiculous tests to do for a 90 year old. It's horrendous. [2.5]

Several mentioned the burden family members’ needs placed on an already tight appointment slot. “Meeting with the family – that takes a ton of time.” [2.3] “Time we don't have.” [2.2]

[Expectations of family members] can be totally different from what the senior may have wanted to talk about. You're kind of dealing with 2 or 3 patients at that point. It can be pretty challenging in a 15 minute visit. [2.3]

Providers reported feeling limited in their ability to handle socioeconomic issues that greatly impacted their patients’ health, such as cost barriers, lack of transportation, and “lack of family resources” [1.1] such as a family member accompanying patients to visits. Providers felt limited by both time constraints and lack of knowledge about available resources. In the words of one practitioner, “I flounder the most around resource issues.” [1.3] Several others expressed frustration with the perceived low quality of available community resources and case management to fill in these gaps:

When I have called [a specific community resource]...I have been unimpressed. I have called in desperation...I get a sweet little volunteer on the phone and my patients end up with absolutely nothing. [3.2]

Limitations of the current health care system were mentioned frequently. The most frequently cited limitation was the insufficient length of appointment times in current reimbursement structures:

You need more time with geriatric patients, and we don't have those time slots allotted for probably the time that we really need for those patients...They usually can't

hear you, so you repeat things several times, and then, it takes them a little bit longer to understand it. And sorting out their multiple meds – all of that takes a lot of time. [6.1]

Some providers had addressed this by extending appointment slots, though this cut into their revenue in the fee-for-service system. According to one interviewee, *“I started allowing 30 minutes instead of 15 for a great number of them, but that’s not very good for the bottom line. We get paid the same.” [2.4]* Another provider said:

I have shrunk my panel size to some degree, and that has helped. It is hard to change the template in which you see patients because we’re still basically a volume-driven business. So I don’t necessarily get paid that much better for someone who has seven problems versus someone who has two or three problems. [3.1]

Various aspects of team-based care came up in several discussions, but most interviewees did not have access to resources such as case managers or behavioral health. Those who were familiar with team-based care were not universally persuaded of its benefits:

I’ve seen the algorithm which you guys work off of [using clinical pharmacists to perform Annual Wellness Visits], and it makes perfect sense, and I’m not saying that it’s not a good thing. I’m just saying it doesn’t have the flexibility to really do what you’re aiming at, which is handling the higher level of [complexity] of care. [3.1]

However, many others were appreciative of pharmacists’ input and certified nursing assistants working to the highest extent of their licensure, and were interested in incorporating more team members as a way of mitigating some of the burdens discussed above:

For the pharmacist to have eyeballs on everybody has been tremendously helpful. [The pharmacist] has been identifying people who could benefit from more services from her. She educates me about guidelines, studies. I would love to have geriatric behavioral medicine and physical therapy (PT) that we could access in the same way. And a care manager. Ideal clinics would have pharmacist, PT, behavioral medicine, case manager in the office – not going anywhere else. [1.1]

Discussion

Physicians reported enjoying their relationships with their older adult patients and feeling satisfied that they bring value to their patients’ lives. They like listening to their stories and maintaining relationships over decades. This allows physicians to better assist their patients with transitions into higher levels of care and with end-of-life issues. Physicians are able to clarify misunderstandings from hospitalization discharge summaries, specialists’ visits, and to reduce unnecessary medications.

However, the number and severity of the challenges described were significant. The major theme is inadequate time. Physicians frequently noted insufficient time made it difficult to: review extensive medication lists and multiple specialists’ visits notes; address different goals for care between physicians and families; address the high costs of medications and physical therapy; and understand, explain, and access community resources. Physicians feel that much of this work, including various clerical activities or social work functions falls upon the physicians to initiate and monitor.

Physicians requested longer appointments with all older adults in order to be able to address their needs, but acknowledged that this was not realistic in a fee-for-service environment. Yet, despite evidence that interprofessional, team-based care using care managers, clinical pharmacists, and/or behavioral health providers improves care for older adults is a cost-effective way to offload work that physicians currently perform,⁷⁻¹¹ these physicians expressed concern about

real life implementation of such a care model. Consistently, the physicians worried about being able to trust that the non-physician team members would be as thorough as they were themselves and about the barriers to reimbursement for other team members' services. Further, physicians worried about not wanting to miss important moments in the care of their patients. These concerns are consistent with Oftedal's observation that when individuals undergo a significant change in systems, their experience includes a sense of loss.¹³⁻¹⁴ In this case, physicians expressed concerns about the loss of contact with their patients and autonomy in patient care.

Limitations

The PI had trained 13 of the 20 participant physicians at MAHEC during their residency. As such, those interviewees were likely familiar with her and her research interests, and they may have felt more comfortable expressing their frustrations with the challenges of caring for older adults. Alternatively, they may have been more reticent lest disappointing a mentor and colleague.

Only family physicians were included in the interviews; five general internal medicine physician groups also provide primary care for older adults in our region. However, since internists and family physicians in the US have reported similar symptoms of burnout, it seems unlikely that the few internists in our region would have substantially different feelings than the family physicians.¹⁵

Conclusions

Family physicians in WNC wish for longer appointment times with their older adult patients to provide the full scope of care needed by patients and their families. Given the current fiscal situation in primary care, this is unlikely to be feasible under a fee-for-service model. Use of non-physician team members, to share in the care of older adult patients, and specific office-based changes have the potential to enhance joy in practice for physicians while simultaneously enhancing quality of care for older adults.⁹

However, if the physicians we interviewed represent the family physicians in WNC, then many family physicians in our region are not currently ready to endorse team-based care, a major component of high quality primary care. Thus, health care organizations in WNC should actively prepare family physicians, and other primary care physicians, for the inevitability of working in interprofessional teams. As hospital-owned practices bring on these team members, physicians will need help in acquiring the competencies needed for effective team-based care.

Mitchell describes the core principles of team-based health care as shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes.¹⁶ These principles should form the core of our efforts to train medical students, family medicine residents, and practicing primary care physicians in our region. Our educational goals should include "...high-functioning teams, improved professional satisfaction, and greater joy in practice."⁹ Primary care providers implementing team-based care in Western North Carolina will be uniquely qualified to address the complex needs of our region's older adult patients while maintaining joy in practice.

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