



THOMSON REUTERS

**SUMMARY OF FOCUS GROUPS CONDUCTED
WITH MEDICARE-MEDICAID BENEFICIARIES IN OREGON**

The Dalles, Portland and Roseburg

July 18-21, 2011

Supported by the Centers for Medicare & Medicaid Services

Medicare-Medicaid Coordination Office

Under Contract No. HHSM-500-2005-00026I

October 19, 2011

Purpose of Focus Groups

The Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare & Medicaid Services (CMS) sponsored a series of focus groups around the country in 2011 to learn more about how Medicare-Medicaid enrollees—persons who are enrolled in both the Medicare and Medicaid programs—experience the health care system. The MMCO has also awarded design contracts to Oregon and 14 other states to plan/develop integrated care models for Medicare-Medicaid enrollees at the state level.

In July 2011, the MMCO sponsored focus groups in Oregon in partnership with the Oregon Health Authority and the Oregon Department of Human Services. The Oregon focus groups contribute both to MMCO's efforts to improve care nationally and Oregon's efforts to reform health care delivery within the State. The objectives of the Oregon focus groups were to:

- Learn about how Medicare-Medicaid enrollees experience care currently, including primary, acute, behavioral health, and long term supports and services;
- Learn about how Medicare-Medicaid enrollees with complex care needs navigate the system, whether or not they perceive fragmentation/lack of coordination, and what their priorities are for improvement; and
- Learn about differences in how the health care system is experienced in different parts of the State, and by people receiving different mixes of services through different delivery systems.

Planning and Conducting the Focus Groups

Thomson Reuters and its partner, The Zacharias Group, conducted the focus groups under contract to the Medicare-Medicaid Coordination Office. Consumer Opinion Services, a market research firm located in Portland, provided logistical support. Based on the objectives above, 3 locations were selected, and profiles were developed for each group to ensure that people with a variety of needs and enrollment combinations (e.g., managed care for both Medicare and Medicaid, fee-for-service for both, managed care/fee-for-service combination) were invited. Thompson Reuters and The Zacharias Group then worked with the Oregon Health Authority to invite 300 persons per group who were randomly drawn from subsets of beneficiaries who met the profile characteristics. (300 random invitations generally yields between 6 and 10 participants.) Six groups were held between July 18 and 21, 2011. Table 1 provides the location, profile and number of participants who attended each group. *Note: in Oregon, Medicaid is delivered through the Oregon Health Plan (OHP).*

Table 1. Description of Oregon Focus Groups

Group Profile	Date & Location	# Attendees
<p>Service Area: Wasco & Hood River Counties Service Delivery: Fee for Service or Managed Care for Oregon Health Plan (OHP) Beneficiaries: Medicare-Medicaid enrollee; 18 years or older; Receive long-term care services</p>	<p>The Dalles July 18, 2011 1:30 p.m. Shiloh Inn</p>	<p>9</p>
<p>Service Area: Multnomah, Clackamas, & Washington Cos. Service Delivery: Fee for Service or Managed Care for OHP Beneficiaries: Medicare-Medicaid enrollee; 18 years or older; Receive long-term care services</p>	<p>Portland July 19, 2011 10:30 a.m. Lloyd Center</p>	<p>6</p>
<p>Service Area: Multnomah, Clackamas, & Washington Cos. Service Delivery: Managed Care for both Medicare & OHP Beneficiaries: Medicare-Medicaid enrollee; 65 years or older; Has one or more of following: 6+ ED visits in 2010; chronic mental health/substance abuse condition; 2 or more chronic conditions</p>	<p>Portland July 19, 2011 1:30 p.m. Lloyd Center</p>	<p>5</p>
<p>Service Area: Multnomah, Clackamas, & Washington Cos. Service Delivery: Fee for Service for both Medicare & OHP Beneficiaries: Medicare-Medicaid enrollee; 18 years or older; Has one or more of following: 6+ ED visits in 2010; chronic mental health/substance abuse condition; 2 or more chronic conditions</p>	<p>Portland July 20, 2011 10:30 a.m. Lloyd Center</p>	<p>7</p>
<p>Service Area: Douglas County Service Delivery: Fee for Service or Managed Care for OHP Beneficiaries: Medicare-Medicaid enrollee; 18 years or older; Receive long-term care services</p>	<p>Roseburg July 21, 2011 10:30 a.m. Umpqua Community College</p>	<p>3</p>
<p>Service Area: Douglas County Service Delivery: Managed Care for both Medicare & OHP Beneficiaries: Medicare-Medicaid enrollee; 18 years or older</p>	<p>Roseburg July 21, 2011 1:30 p.m. Umpqua Community College</p>	<p>9</p>
Total All Groups:		<p>39</p>

Beneficiaries who requested assistance received transportation. The groups included several participants who used wheelchairs or walkers for mobility. The groups were moderated by Lee Zacharias and lasted 90-120 minutes. (For more details on how participants were recruited, see Appendix A.)

The moderator used a discussion guide to ensure that key topics were addressed, but also allowed and encouraged spontaneous discussion. Thompson Reuters and The Zacharias Group reviewed transcripts from the focus groups and summarized participants' responses by objective (see below). Additional observations came up frequently that did not directly address any of the 3 objectives. Those are summarized as "Other Observations."

Findings by Objective

Objective 1: Learn about how Medicare-Medicaid enrollees experience care currently, including primary, acute care, behavioral health and long term supports and services.

- Near universal access to primary care was reported. The groups were split on length of relationship with a Primary Care Provider (PCP), with some having multi-year relationships, and others experiencing frequent turnover. Some people reported having a relationship to a clinic but not an individual. ("I see whoever they give me.")
- Most reported seeing their PCPs regularly, which ranged from once a year to once a month. Many reported being contacted by their PCP offices to set up appointments, or to be reminded of appointments.
- Participants spoke about the "15 minute limit" that many doctors practice, especially reported by participants in Portland.
- A few participants reported very special relationships with their PCPs. One doctor spent 30 minutes with a patient and provided gas money because a prior appointment had been missed by the beneficiary due to lack of transportation.
- Hospital use within the past year was widely reported. Most said they had been admitted through the emergency department. Many had gone directly to the emergency department without consulting their PCPs. Many reported that they had consulted their PCPs and were told to go directly to the emergency room.

- Most participants reported taking multiple prescriptions. Those with multiple co-pays noted that the total can be prohibitive in a month, but that filling their prescriptions is a priority.
- Many participants reported that they took medication for pain, and some complained about not being able to get an adequate supply. (“What they give me for a month is not enough to take care of my pain.”)
- Participants receiving long term services and supports (LTSS) usually reported their service in terms of hours. (“I get 66 hours a month.”) Several reported that their paid caregivers were family members. Several reported that finding a good caregiver could be difficult, and that they worked hard to retain a caregiver once they found one they liked (e.g., being flexible about schedule).
- Although several participants reported mental health conditions, mental health services rarely came up in the discussion.
- Poor access to eye and dental care was reported at all locations.

Objective 2: Learn about how Medicare-Medicaid enrollees with complex care needs navigate the system, whether or not they perceive fragmentation/lack of coordination, and what their priorities are for improvement.

- Participants reported seeing many specialists in addition to their PCPs. This was reported among both participants who receive LTSS and those who do not. Some reported coordinating this themselves, or with help from family members or friends. Others said their PCP office helps coordinate specialist visits.
- Participants associate their case workers primarily with access/eligibility issues (e.g., annual recertification, assistance with gaining benefits or re-gaining them if lost). LTSS users also associate case workers with getting authorization for “hours” of assistance.
- Participants do not associate case workers with clinical integration or coordination across medical and social supports. Most participants compartmentalize the two parts of their care, with the PCP or PCP Office helping with clinical coordination, and the case worker helping with eligibility and social supports.

- In all locations, there was a perception that case workers had experienced increased workload due to cuts in staffing. When asked how they knew, some indicated that it was taking longer for case workers to respond to calls. One person noted that her case worker calls her in the evening, which she took as an indication that the case worker had too much to do during the day.
- Some reported that their PCPs knew immediately or soon after they were admitted to the hospital, and wanted to see them soon after discharge. Others reported that their PCP did not know about admissions.
- In Portland, participants expressed the perception that PCPs have medical information but do not read it. (“I know they have my information, but the doctor starts over because he hasn’t taken the time to read the notes.”)
- Most participants believed that their prescriptions were coordinated among their doctors, though one participant reported having been given 4 independent prescriptions for hypertension by 3 different doctors.
- Many participants reported getting help from their pharmacists. Examples included a pharmacist noting that a person had not filled a prescription, and a pharmacist asking about a change in medication.
- Several participants reported using nontraditional forms of providers/healthcare, such as homeopaths. This was perceived as particularly difficult to coordinate due to limited acceptance by PCPs of alternatives as legitimate. (“When will the system catch up?”)
- Participants who were veterans reported good coordination within the VA system. (“The beauty of the VA is it’s all in the computer.”)
- Many people spoke of the important role that caregivers played in helping them navigate the system (e.g., making appointments).

Objective 3: Learn about differences in how the system is experienced in different parts of the State, and by people receiving different mixes of services through different delivery systems.

- Turnover among case workers appeared to be a greater concern in Portland than in the other locations.

- All of the Roseburg participants belonged to the dominant health plan in the area, with most enrolled for both OHP and Medicare. The general sense of most participants there was that they did not have much choice in the matter. One participant reported that when she asked about Medicare FFS, she was told she had a right to that option, but that none of the providers in the area would take it.
- Roseburg participants reported a fair amount of unhappiness with providers, particularly the local hospital.
- There were several complaints in Roseburg about the plan imposing limits on the number of visits (e.g., physical therapy, chiropractic). This was not commonly expressed among managed care enrollees in Portland or The Dalles.
- The Dalles participants appeared to be more satisfied with coordination than participants from other areas. There was a strong sense there that their PCP and specialists were in close touch with one another. Participants in The Dalles reported that their PCP knew when they were admitted to the hospital and wanted to follow up with them upon discharge.

Other Observations

- Most beneficiaries understand that OHP is Medicaid, and that Medicaid is a separate program from Medicare. Many knew that Medicare pays first and OHP pays cost sharing and services that Medicare does not cover. (“OHP makes Medicare work for me.”)
- Many participants reported that OHP is reducing benefits. (“The State is cutting back.”) Some reported that they are concerned about what will happen to Medicare in the federal budget.
- Participants clearly knew that Medicaid and Medicare are government programs, yet at least once in each group, a participant expressed the view that the government should stay out of healthcare coverage.
- Participants generally reported that they were in control of and involved with their healthcare decision-making.

- When asked what was working well with their health coverage, many expressed general appreciation for having comprehensive coverage. (“I get what I need.”) Many noted good relationships with their PCPs as something that was working well. (“I can tell my doctor anything.”)
- When asked what they would like to change, participants were more specific. Responses included:
 - Eliminate duplication of testing that occurs (PCP tests, then refers to specialist, who runs the same test).
 - Improve access to pain medication. (“They treat you like a criminal.”) PCPs could do more checking to distinguish symptoms of pain from addiction and depression.
 - Better coverage for dental and eye care.
 - Better coordination of care. (“I need to do a lot of the leg work.”)
 - Higher quality supplies (e.g., pads are too small and thin).
 - Allow edits to what case workers write in the file.

Implications

Focus group results can provide new insights into how people perceive or experience systems, but even with the efforts that were taken to randomize participation in the Oregon focus groups, care must be taken not to over-generalize from the experience of a small group. With that limitation, the observations of Medicare-Medicaid enrollees in Oregon suggest several areas worth greater focused study as the State implements health reform.

PCPs

Access to PCPs is nearly universal, but the quality of the interaction appears to vary widely, despite all participants having the same health coverage. Patient engagement, after-hours access, and coordination with specialists, hospitals, and ancillary services are uneven. More consistent provision of PCP services may be an opportunity to improve care and cost effectiveness for some beneficiaries.

Dental and Eye Care

Lack of access to dental and eye care are great concerns to beneficiaries. Coverage would clearly have very broad marketing appeal as value-added services, or as incentives in the context of promoting wellness.

It may be worth investigating (through claims analysis) whether there is a relationship in Oregon among dental pain, use of emergency departments and use of pain medication.

Mental Health Services

Many participants reported having both mental health and physical health conditions. Given this and the fact that many participants also reported taking pain medication, there may be opportunities for PCPs and behavioral health providers to work together to integrate care for beneficiaries.

Case Management

The role of the case worker is compartmentalized in Oregon. Case workers are viewed largely as people who can assist participants in getting coverage and help people make the most advantageous decisions about eligibility-related issues. Even among those using LTSS, the case worker was not seen as someone involved in the medical system. The role would need to change considerably, and competencies expanded, in order for existing case workers to play an over-arching coordination role. The medical and LTSS systems appear to operate in parallel, missing opportunities to provide a holistic, integrated experience for beneficiaries.

System Change

The relatively high levels of dissatisfaction in Roseburg were very likely related to recent closure of a local hospital and consolidation of the health care market there, which has required many beneficiaries to change health plans, providers, or both. This suggests that program planners and policy makers in Oregon need to incorporate transition strategies and public communication into the reform process. Specifically, if beneficiary choices will change under health reform, significant education and assistance with choices are likely to be needed.

Satisfaction

Despite describing situations with serious shortcomings, most participants expressed general satisfaction when asked what is good about the system. This reinforces the need to move away

from general satisfaction as an indicator and incorporate more measures of beneficiary experience.

Appendix A. Focus Group Recruiting Methodology

Thomson Reuters and The Zacharias Group (TZG) staff worked with staff from the Oregon Health Authority (OHA) to develop and carry out the following recruitment plan:

- Based on the objectives for the focus groups, a profile for each group was developed that included service area, service delivery system (e.g., managed care or fee-for-service) and beneficiary characteristics. (The profile of each group is included in Table 1 of the report.)
- For each group, OHA drew a random sample from their client files of 300 persons who met the profile for that group. 300 random invitations generally yields between 6 and 10 focus group participants.
- 3 weeks prior to the focus group dates, OHA mailed written invitations to the randomly selected persons. The letters instructed interested persons to call TZG at a toll-free number if they wanted to volunteer for a group. As an incentive for this voluntary activity, the letter offered a \$50 gift card to those selected. The letter also offered assistance with transportation. The letters included security codes to ensure that only invited persons would be considered for groups.
- Calls were received by the focus group moderator who asked screening questions to ensure that the caller met the group criteria and held a bona fide invitation. Details were provided including an explanation that the group would be audio recorded, and would be observed by members of the research team and representatives from the state and federal governments. Callers who met the screening criteria and who stated they wanted to participate were asked for their verbal consent at that time and were told that a written consent would be completed at the group itself. Interested persons were also asked to provide contact information for follow-up confirmation.
- One week prior to the focus group dates, TZG sent a letter to participants confirming date, time, and location of the group (and transportation source if applicable). Participants were encouraged to contact TZG if they had any questions or concerns and/or if they felt they would be unable to participate.
- On the day before the focus groups, focus group participants were contacted to remind them of the groups and confirm any transportation arrangements required.