2015

Assessing the Impact of Major Health Policies on Provider Practice

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This is to certify that the doctoral dissertation by

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2015

Abstract

Assessing the Impact of Major Health Policies on Provider Practice in the United States

by

Nadine Josephs

MS, Temple University, 2003

BS, University of the West Indies, 2001

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Care Administration

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November 2015

Abstract

Many health care stakeholders have expressed concerns with the distribution and availability of primary care physicians (PCP) across the United States. Despite programs such as Healthy People 2010 and 2020 Initiatives, statewide and local health care expansion efforts and policies; access to PCP remains a challenge for health care consumers. The purpose of this mixed method research study was to evaluate the impact of several health care access policies on the practices of primary care providers and assess their perspectives regarding disparities in access. Patton and Sawicki's policy analysis and evaluation process was the framework used in this study as it is a practical framework for evaluating the impact legislation has on primary care providers' practices. 1,050 surveys were mailed to potential participants, and 861 completed surveys were used in the quantitative data analysis. Purposive sampling was used to select 15 PCP to further assess their perspectives on disparities in access. The quantitative data was analyzed using SPSS Statistics Version 21 software program. All evidence that contained text was coded, analyzed to identify patterns and theses, and subjected to data triangulation, and member checking. The findings illustrated that PCP are not involved in health policy development and evaluation processes, do not fully understand some policies, and are dissatisfied with the impact health legislation has on their practices. The findings will help in expanding the PCP workforce, improving access to health care providers, and reducing health disparities. Clinical decisions and practice patterns may also be improved once providers' knowledge and participation in health policy development and evaluation are improved.

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Dedication

To all those that I love, this one is for you.

Acknowledgments

I thank God for providing the motivation, strength, and determination to complete my dissertation. Without God, this would have been impossible.

Special thanks to my family for the patience, love, and support. Your encouragement was my inspiration.

Thank you, Dr. Amy Thompson, for your patience, wisdom, and valuable input. This could not be possible without you. Dr. Diane Cortner, your encouraging words, availability, and input will forever be appreciated and cherished.

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Chapter 1: Introduction

There is a shortage in practicing primary care providers in the United States (Young, Chaudhry, Thomas, & Dugan, 2013). The Agency for Healthcare Research and Quality (2015) estimated that there were 208,208 practicing primary care physicians in the United States in 2010. These physicians serve a population estimated at over 317 million, causing health care stakeholders to continue face challenges in expanding access and availability to many health care providers (U.S. Department for Health & Human Services, 2013a). Expanding access to health care services is not only a challenge for national health care policymakers, but also for stakeholders in rural, urban, and suburban communities (Grossman, 2009). U.S. health care consumers currently experience and are predicted to continue to experience difficulties in accessing primary health care services (Grossman, 2009). One of the United States Department for Health and Human Services (USDHHS) Healthy People 2020 Initiatives is to increase the number of practicing primary care providers (PCP) as part of increasing the general supply of the health care provider workforce (U.S. Department for Health & Human Services, 2013a).

Several studies have analyzed the relationship between disparities in access to primary care services in the United States and health insurance coverage. Grossman (2009) evaluated local and national efforts focused on expanding access to primary health care services, concluding that access to and utilization of primary health care services are not guaranteed by one's health insurance coverage. On the other hand, Collins and O'Brien (2011) concluded from their study that individuals are unable to access health care services largely in part due to the lack of health insurance coverage. These findings

suggest that some individuals are unable to access primary care services due to the lack of health insurance, and others who have health insurance coverage may face restrictions in the obtaining care.

According to the US Department of Health & Human Services (2013b), approximately 83.2% of persons in the United States had medical insurance in 2008. While the target goal of the USDHHS's Healthy People 2020 program is to have 100% of the population have health insurance coverage, the actual number of insured persons in 2008 represents a fairly high level of insured individuals (Derose, Gresenz, & Ringel, 2011). Despite an estimated eight out of 10 Americans having health insurance coverage at the time of this study, many were unable to utilize the services of licensed health care providers (Derose, Gresenz, & Ringel, 2011). According to the authors, access to care is a multi-faceted topic which has several major contributing factors. Health insurance coverage is only one aspect of being able to access the services of health care providers (HCPs); another factors identified is the adequacy or lack thereof of HCPs (Derose, Gresenz, & Ringel, 2011).

According to Boyle (2011), addressing disparities in access to care must begin with an evaluation of basic economic principles of demand and supply. A change in one principle often influences the other (Brock, 2012). (Boyle (2011), Cooper (2009), and Dewitt (2010) evaluated the economic relationship between the supply and demand for health care services. Despite these studies' findings supporting the value of economics in health care and the importance to continue assessing the supply of health care services, limited literature exists on the impact policies have on the availability of health care

providers. Brock (2012) concluded that majority of the current recent literature only examined the impact of demand-related health access improvement strategies and ignored any impact these may have on the supply or adequacy of health care providers. Brock (2012) argued that stakeholders should use proactive and "community-specific strategies" rather than utilizing a one-size-fits-all approach (Brock, 2012, p. 30) to improve access to health care providers.

Several reactive measures have often been developed to address HCP shortages. Mongan and Lee (2005) examined the geographical distributions of HCP within several states, finding a relative shortage of primary health care providers across many areas, especially rural communities. Health legislation improving or expanding access has been the main measure used to address primary health care provider shortages (Brock, 2012). Legislation such as the United States Marine Hospital Service dating back from the 1700s was implemented to improve access to health care services for service men and women in local communities (U.S. Marine Hospital, n.d). Since then, additional policies at both the national and state levels have been developed and implemented with the aim of improving not only access to health care services for patients.

These policies and laws are also designed to improve the distribution and availability of health care providers in communities across the US. For example, the Rural Health Clinic Services Act (1977) and the Patient Protection and Affordable Care Act (PPACA) (2010), were designed to improve access to health services for health care consumers (Brock, 2012; Grossman, 2009; Kaplan & Brown, 2007). The Rural Health Clinic Services Act was specifically designed to improve access to health care services

for residents living in rural communities in the United States, as well as to expand the number of health care providers primarily nurse practitioners serving in these rural communities (Mongan & Lee, 2005). Similarly, the PPACA, which was fully implemented in 2014, was designed to expand health insurance coverage to many uninsured Americans and to improve the distribution of the supply of health care providers (Williams, McClellan, & Rivlin, 2010).

Boyle (2011) proposed that future research should assess the role these health policies have had on the prevalence of health disparities. While this is a broad topic to explore, there is limited recent literature on the potential negative effect health policies have on the adequacy and willingness of primary care providers to deliver health care services. Some stakeholders have contended that the lack of a national health care system or workforce policy contribute to disparities in the supply of services by health care providers (Trotter, 2011). Other stakeholders have openly expressed support for state-led initiatives as the only viable resolution to address disparities in the health care workforce (Cooper, 2009). Although both positions have been supported with evidence (Buchan, 2010; Collins & O'Brien, 2011; Cooper, 2009; & Trotter, 2011), there still exists a gap in literature of the impact major health policies have on limiting the availability of primary care providers. Few studies have examined the sources of the disparities in the supply of health care services, and increasing disparities in access. No recent research has analyzed the role health legislation implemented to expand the demand for health care services, may have on decreasing the supply of health care services, as well as increasing disparities.

The purpose of this research study was to demonstrate that recently enacted health policies in the United States negatively impact the satisfaction of PCPs and their practices. To date, there has been no record of a study assessing the impact health legislation has on primary health care providers' willingness and ability to deliver care. Understanding the effect these legislation have on primary care providers' practices is very important to local and national health care policymakers. Patton and Sawicki (1993) stated that policy analysis is a foundation for future policy development. Dunn (2004) further explained that the assessment or evaluation of existing policy should be integrated into any policy analysis before any changes can be made. Therefore, this study was designed to collect information needed to and improve policy development and evaluation processes, provide scholarly evidence for future research, and reduce disparities in access.

Background

The practices of health care providers in the United States are governed by state and federal laws, regulation, and professional policies (Blumenthal, 2004). Most of these laws, regulations, and legislation have been developed and subsequently analyzed for their focus on the demand for health services, without examination of their effect on provider practice (Bennett, Corluka, Doherty, & Tangcharoensathien, 2012). Boyle (2011) and Brock (2012) explained that this is a one-sided or consumer-driven analysis that is unable to adequately address the observed disparities in access. Equal attention should also be placed on the supply of health care services and the willingness of health care providers to deliver these services within the scope of their education and training

(Green, Savin, & Lu, 2013). Limited knowledge exists on any direct impact that major U.S. health legislation has on the practices of health care providers (Running, Hoffman, & Mercer, 2008).

Access to health care services includes patients being able to obtain care (demand for services), as well as the availability of health care providers delivering health care services (supply of services). While several efforts have been implemented to improve the utilization of health services, recent reports have indicated that individuals are unable to obtain preventive services and sometimes significant delays in receiving care (U.S. Department for Health & Human Services, 2013a). Additionally, current and anticipated shortages in the primary care provider workforce, suggest a need to examine whether the availability or willingness of primary care providers to deliver health services of HCP are restricted by some existing health policies (Greysen, Richards, Coupet, Desai, & Padela, 2013). Recent literature has not assessed the relationship between policies and physician availability, and how these may be contributing to disparities.

Much of the extant literature on these aspects of U.S. health care has focused on the relationship between access to care and health insurance coverage. As reiterated by Brock (2012), little emphasis has been on the relationship between health care legislation and the delivery of health services by HCP. This dissertation was designed to identify the restrictions that U.S. primary health care providers believe are the result of major health access policies. The dissertation's central purpose was to analyze the relationship between major health access policies in the United States and primary health care

providers' willingness and availability to deliver health care services, and to further evaluate how these restrictions contribute to disparities in access.

Problem Statement

Health care stakeholders have identified the inadequate distribution and availability of primary care physicians, and other health care providers across the United States as major challenges in access to health care providers (Cooper, 2009). Sager (2013) stated that this is a known issue but few measures have been effective in preserving or expanding the capacity and availability of health care providers in the United States (p. 67). Strategic efforts such as expanded educational and residency programs, loan forgiveness, and expanded autonomy at the state and federal levels have been implemented to improve the long-term availability of health care providers (Jacobson & Jazowski, 2011). Despite these efforts, shortages exist in the supply of health care providers in the United States (Iglehart, 2009).

Multiple sources have argued for reforming health care and health care assessment in the United States. Runy (2009) argued that the US health care delivery is mostly impacted by the availability and willingness of health care providers to provide health services. Improving access to health services can therefore no longer be assessed primarily by the utilization of services by consumers or patients (Levesque, Harris, & Russell, 2013), but must also be assessed by the availability of health care providers (Huicho, Dieleman, Campbell, Codjia, Balabanova, Dussault, & Dolea, 2010). According to the 1993 report published by the Institute of Medicine, improving access to health care services and providers, and eliminating health disparities can only be

achieved through health care reform (Institute of Medicine, 1993); decades later, this view is still supported and encouraged (McLaughlin, 2005). However, little current evidence has been collected to assess the impact previous reform efforts may have on the supply of services by primary care providers.

Expanding the number of medical programs and facilities, and providing more attractive loan forgiveness packages increases the supply of primary care providers (Collins & O'Brien, 2011). However, as stated by Iglehart (2011), the success of these efforts in the United States has been significantly reduced by a fragmented US health care delivery system and its potential to limit how health care providers practice. This creates a problem in which health care policies developed to expand or improve the availability and utilization of health services to health care consumers, have a significant potential to directly or indirectly restrict the types and levels of services offered by health care providers. Limited literature exists on how these factors do or do not contributing to the increasing prevalence of disparities in access. This dissertation was specifically designed to address this broader research problem by describing the restrictions primary care providers identify are the results of health policies and analyzing how these restrictions affect access to primary care providers and contribute to disparities.

Purpose of the Study

The purpose of this study was to analyze the relationship between major health care access policies and physician availability in the United States, with a specific focus on how primary care providers deliver primary health care services. Understanding how these policies are restricting the delivery of primary health care services is an important

requirement for informing future health policy development and implementation processes. For the purpose of this study, a primary care provider practice was defined as the setting in which a licensed individual trained for and skilled in comprehensive and continuing care is willing and able to deliver health care services to the scope of their education and training (Currie, 2013).

This dissertation includes a brief historical reflection and evaluation of several major acts of legislation that were developed and implemented to expand access to health services, and the impact these have on restricting the services of primary care providers. The Institute of Medicine (1993) defined disparities in access as the lack of timely use of personal health services that could be used in achieving the best possible outcome. While it is important to highlight that individuals may not be able to access health services due to the lack of health insurance coverage or the constraints associated with having this coverage (Blumenthal, 2006), the focus of this dissertation was on the role health care access policies play in contributing to the shortage in the primary care workforce. The research sought to examine the relationship between the health policies highlighted in Chapter 2, and the availability of primary care providers. Understanding this relationship can assist policymakers develop policies that PCPs understand and support, attract and retain practicing PCPs, and improve methods of evaluating the impact of local and national policies on the availability of primary care providers. This research shows that many PCPs are dissatisfied with the impact of legislation on their practices, and experience restrictions to their services due to these policies. Health care administrators and policymakers in their efforts to lower health care costs, reduce PCPs turnover rate,

improve PCPs satisfaction can utilize the findings and recommendations of this research to PCPs availability and improve access to their services.

The purpose of this doctoral research study was to assess the relationship between major health access legislation in the United States ,and the availability of primary care providers, and examine the perceptions of primary care providers' perceptions regarding reducing disparities in access. The results of the data identify measures that can be used by health care stakeholders to evaluate existing health policies. This doctoral research can also be used by health policymakers in developing local, and national health care delivery and quality improvement programs,.

Nature of the Study

I examined the views of primary care providers in the United States on the impact several major health policies have on how they currently deliver health services, including how these may contribute to the prevalence in disparities in access. Additionally, I analyzed the relationship between disparities in access and health policies. Because it was necessary to ascertain the disparities before any relationship can be analyzed, I selected a mixed methods study design.

The preliminary analysis used to determine these health care disparities was completed through a review of historical local, state, and national information on access to care in the United States. The nature of the study was a mixed-methods study with a qualitative focus. I utilized a survey to identify the types and prevalence of restrictions or limitations primary care providers identify within their practice, followed by semistructured interviews conducted later by phone with a small subset of the

participants. This qualitative focus then examined the perceptions of primary care providers on the role these legislation play in contributing to disparities, as well as their recommendations on how best disparities in access can be reduced or eliminated. This mixed-methods study was consistent with the goals of understanding the current state of the supply of primary care providers and exploring how this is impacted by major health care legislation.

Research Questions

The research study addressed two research questions. These are:

1. What is the relationship between major health access legislation in the United States and the availability of primary care providers?

H_0: There is no relationship between health access legislation and the availability of primary care providers to deliver services.

H_1: There is a relationship between health access legislation and the availability of primary care providers to deliver services.

2. What are primary care providers' perceptions regarding reducing disparities in access?

Conceptual Framework

According to Marmor and Wendt (2012), a conceptual framework serves as a constructed map helpful in defining the relationship between an issue and its contributing factors. In order to understand the impact health access legislation has on the willingness of a health care provider to deliver health services to a patient, a conceptual framework should be developed. This framework will then explore the relationship that exists

between these variables (Marmor & Wendt, 2012). The authors described the conceptual framework as an action-oriented plan (Marmor & Wendt, 2012), which could promote change in health care delivery though policy analysis and evaluation processes.

Eliminating disparities in access is one aspect of a broader policy issue related to improving the delivery of health care services in the US (Bennett, Corluka, Doherty, & Tangcharoensathien, 2012). One of the missions of the Healthy People 2020 program is to strengthen and improve various healthcare policies (U.S. Department of Health & Human Services, 2013b). One goal related to this mission is expanding access to health care services with more effective policies (U.S. Department of Health & Human Services, 2013b). Various health care stakeholders offer valid arguments on how this should be achieved. One of the benefits policy evaluation provides is the opportunity to evaluate the evidence-based strategies that have been utilized in the development of health access policies which can be incorporated into programs or strategies aimed at reducing disparities in access.

Disparities in access to health care services are one of the issues health care stakeholders are attempting to address (Currie, 2013). Patton and Sawicki (1993) recommended that the facets related to disparities in access be identified and each be analyzed individually. One ignored topic related to disparities in access is the restrictions health care providers face in delivering care (U.S. Department of Health & Human Services, 2013b). This particular aspect should be analyzed in order to determine whether health policies such as the Patient Protection and Affordable Care Act (PPACA) and

those under Medicare and Medicaid, are indirectly restricting access to the services of health care providers, which may also be contributing to other health care disparities.

The availability of health care providers is only one component of health care access (Brock, 2012). An evaluation of existing statistics on the health care workforce and its future projections provides an opportunity to consider the impact several policies have on where and how providers practice. To date, limited research exists on the real impact of policies such as those developed by the Centers of Medicare and Medicaid Services or state agencies have on the availability and willingness of primary care providers to deliver health services. This policy analysis and evaluation framework can provide an evidence-based platform for future research, policy development, and evaluation. Using this framework, this doctoral study assessed the intended goal of these health policies in comparison to their achievements (Kraft & Furlong, 2010).

Policy analysis has several functions including analyzing the components of the policy making process, and evaluating the substantive issues within the policy (Kraft & Furlong, 2010). Dunn (2004) stated that policy analysis and evaluation not only provides a potential solution for achieving a specific overarching goal, but also provides guidelines helpful in examining specific elements of a goal. A growing body of literature supports the use of policy analysis in addressing disparities (Collins & O'Brien, 2011). Additionally recent literature focusing on improving the US health care delivery system highlights the need to collect and interpret information that clarifies the causes and effects of policy issues. Chapter 2 will provide a more thorough explanation of this framework.

Definition of Terms

Access: According to the healthcare access model presented by Penchansky and Thomas (1981), access refers to the availability, affordability, accessibility, acceptability and accommodation between the suppliers and consumers within a health care system. For this study, the emphasis will be on availability and accessibility of primary care providers.

Disparity: Disparity as defined by the Institute of Medicine (1993) is "a difference in access or treatment provided to members of different racial or ethnic groups that is not justified by the underlying health conditions or treatment of patients" (p. 19).

Health care provider: A licensed individual supplying curative, preventive, or rehabilitative health care services in a systematic way to individuals (Iglehart, 2009). For this study, the health care providers being assessed were primary care providers.

Health care workforce: All licensed health care providers who deliver direct patient care and support responsibilities, including but not limited to: physicians, nurses, nurse practitioners, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, allied health professionals, psychologists and other behavioral and mental health professionals (de Filippi, 2010). For this study, the health care workforce under study was limited to actively licensed and actively practicing primary care providers.

Health policy: The plans, decisions, and actions undertaken to achieve specific health care goals within a society (Robert Wood Johnson Foundation, 2013). The policies assessed in this study were major ones or portions that have been enacted by either the state and or federal government whose specific goal is to improve access to health

services for patients or consumers. The major polices examined were the Patient Protection and Affordable Care Act, policies developed by the Centers for Medicare and Medicaid Services, and health reform policies developed at the state level.

Health care supply: The number of trained health care providers working in a health care system or active in the labor market (U.S. Department of Health & Human Services, 2013b). The specific health care supply examined in this study was the number of actively practicing primary care physicians.

Primary care provider: A health care practitioner who sees people that have common medical problems (Medline Plus, 2014). Primary care providers in this study are described as physicians practicing family medicine, general internal medicine, or pediatrics whose primary role includes identifying and treating common medical conditions, provide preventative care and teach healthy lifestyle choices, assess the urgency of patients' medical problems, and make referrals when necessary (Medline Plus, 2014).

Assumptions

This study used several operating assumptions. These were:

1. It was assumed that participants would be honest in their responses.
2. It was assumed that the data collection instruments used were the best possible tools for assessing any impact major health legislation that have on the disparities in access due to restrictions primary care providers face in their practice.

3. It was assumed that any revisions made following the study would not alter the overall intent of the instruments used in the study.

Health policies are a necessity in health care delivery, and consist of precise actions, plans, or decisions are implemented to achieve specific health goals (Cooper, Hill, & Powe, 2002). However as Cooper (2009) explained, the scope of their designs can contribute to many of the challenges or issues existing in America's health care system. Published peer-reviewed researches with supporting and opposing views were reviewed on the efficiency and relevance of these health policies. However, both views can be challenged.

In order to understand whether primary care providers may be unwilling or unable to practice due to requirements of these health care access policies, it was necessary to examine the current state of the availability of primary care providers. Majority of the peer-reviewed literature reflects a current and anticipated shortage of primary care providers; however, there is little consensus on the reason for the shortage (Apodaca, 2007), and even more limited research on the post-implementation impact health policy has on the practices of primary care providers (Shaw, 2012). Apodaca (2007) and Shaw (2012) cautioned the development of additional legislation to address these disparities without analysis of the failures of inefficiencies of current legislation.

Limitations

The primary limitation of this study was the small sample size that was used in the qualitative data collection phase. The quantitative section of the study consisted of 861 primary care providers, and the qualitative section had 15 participants. As with

previous research that used a small sample size, the risks for bias and generalizations by the researcher increase. While the sample intended to include primary care providers practicing across several states, the actual geographic locations of participants can limit or eliminate possible generalizations that can be made about the impact legislation have on restricting the practices of PCP.

Another limitation of this study is the mix of participants who were included in the study. Currently, primary care providers are not limited to physicians; but in some practices these do include other health care providers such as nurse practitioners and physician assistants. My aim as the researcher was to have a sample of only primary care physicians. The analysis was limited to only the primary care physicians who participated in this study.

Additionally, the different state policies in effect may limit the possible comparisons that can be made. A purposive sampling technique was to select participants, and while 869 respondents returned the survey, only 861 participants were included in this study. Additional limitations of this study will be discussed further in Chapter 3.

Scope

The scope of this study comprised of health care providers practicing in communities in the US during the last five years. The total population identified for this study was 1,050 primary care physicians currently listed as actively practicing on the lists purchased from the American Medical Association and the Medical Professional database website, www.physiciansdatabase.com. This study was limited to primary care

physicians. The aim of the researcher was to include primary care providers who have at least 10 years of professional practice. Both male and female PCP practicing in sole proprietorships, physician groups, hospital and other health care settings were included. All participants were required to give informed consent, and no potential participants were excluded based on race, gender, or practicing locations.

Delimitations

The study did not examine the impact of contributing factors such as malpractice insurance on the practices of health care providers. According to the 2010 National Healthcare Disparities Report, malpractice insurance continue to be a major obstacle for many health care providers and do limit the type of services they provide (U.S. Department for Health & Human Services, 2013a). As discussed in this report, this can restrict provider practice, and in some cases prevent patients from obtaining health services (U.S. Department for Health & Human Services, 2013a). As a result, its impact should be assessed in disparities research. This also presents an opportunity for future research studies.

Significance of the Study

This dissertation is unique because it addressed an underresearched area in the United States health care delivery system (Williams, McClellan, & Rivlin, 2010). As political, economic, social, and health discussions surrounding the implementation and effectiveness of the PPACA continue to occur, many argue about the various potential effects this legislation will have on health care delivery. Expanding health insurance coverage to an additional thirty million Americans will not entirely improve the access

and utilization of health services by patients (Williams, McClellan, & Rivlin, 2010). Also, increasing the number of practicing health care providers across states through loan forgiveness, expanding the scope of practice, or the building of new health care educations facilities, have not translated into improvements in the nation's health care delivery system, or disparities (Stephens & Ledlow, 2010). Despite these measures, one of the goals of the Healthy People 2020 Initiative is expanding access to care (U.S. Department of Health & Human Services, 2013b). The solution to reducing the disparities in access extends beyond the expansion of health insurance coverage for health care consumers, and expanding the supply of health care providers (Stephens & Ledlow, 2010). Sekhri, Feacham, and Ni (2011) encouraged future research on access be focused on understanding the factors that contribute to these disparities. One such factor is the impact health policy has on health care providers' ability and willingness to practice.

The results of this study provided insights into the limitations or restrictions health care providers identify in their practices. Findings from this study can aid health care policymakers in examining the effectiveness of existing policies, and developing policies that will improve access to PCP. Additionally, increased awareness on the limitations or restrictions PCP face daily in their practices can be further assessed and factored into strategies focused on reducing disparities in access. Programs such as the Healthy People Initiative can include the findings of this research into future public health goals.

Health care legislation will continue to be developed and implemented. However, their influence and subsequent effect on the demand and supply for health care services may be different than what is anticipated. If legislation continue to limit or restrict the practices of PCP nationwide, attempts of any real health reform will be unsuccessful. For example, if physicians continue to not see Medicaid patients due to this payer's reimbursement policies, or legislation continue to limit the scope of practice of nurse practitioners; then to many health care stakeholders there will be a shortage or limited supply of health care providers.

Social Change Implications

The PPACA was fully implemented in 2014. Many health care stakeholders agree that more effective strategies or legislation are needed to improve access and utilization of health services. Both proponents and opponents of this legislation agree that access to health services will now be expanded; however, concerns exist about how this will affect the health care workforce. With the focus on preventive care, the current shortage in the number of primary care providers suggests that the workforce may be inadequate to meet the current and future health needs of the population. While it is true that this and other health policies have been implemented to expand the health care workforce, disparities in access will remain prevalent until the restrictions PCP identify that limit the availability of health care providers are assessed and eliminated. Any attempt to address disparities in access should examine the supply and availability of the health care workforce through policy analysis and evaluation.

According to the Walden University's 2012-2013 catalog, positive social change is "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies. Positive social change results in the improvement of human and social conditions" (Walden University, 2013, p. 5). This institution supports positive social change through developing scholar practitioners. From this development, both individuals and society can then benefit from the positive social change.

The implication for positive social change this study proposes to policy makers and other health care stakeholders will be more effective measures and methods to analyze and evaluate the impact of existing health care access policies. Through policy analysis and evaluation, health care stakeholders can develop new legislation that will reduce the disparities in access to health services and providers. Identifying the relationship between major health legislation and the adequacy and availability of health care providers to practice, can not only add to the scholarly literature library, but also improve access to health services, reduce some health disparities, as well as improve the quality of services delivered.

Summary and Transition

The purpose of this chapter was to provide the background for the study. Additionally, this chapter sought to clarify that the study will examine the relationship between several major health legislation and the practices of health care providers. The chapter also presented the research question and the research design that were used to answer these research questions. The conceptual framework and the definition of key

terms were also presented. Included in this chapter were also the scope, limitations, purpose, and the delimitations of the study. The implications for social change or the benefits that could be gained from conducting the study were also discussed. The next chapter, Chapter 2, will provide an overview of literature on these health policies, and the most recent assessment of the disparities in access to health care services.

Chapter 2: Literature Review

Introduction

Prior research studies on disparities in access have focused primarily on health care consumers, or the demand and utilization of health services (Cooper, Hill, & Powe 2002; Dowell, 1987; Freed & Stockman, 2009; Pardes, 2009). While many health care stakeholders agree that all disparities in the American health care system should be addressed and eliminated (Freed & Stockman, 2009), recent data published by the United States Department of Health and Human Services shows increasing trends in several health disparities (U.S. Department of Health & Human Services, 2013b). The persistence of these disparities over many years has led U.S. policymakers to develop and implement several health policies intended to expand access and utilization of health care services (Collins & O'Brien, 2011). While there are such policies identified, this study focused primarily on the Patient Protection and Affordable Care Act (PPACA).

Several authors have debated the need for the United States to have a national health care providers' workforce policy managing the distribution of providers across the US. Cooper and Aiken (2006) argued that disparities in health care access in the U.S. remain prevalent due to the lack of a national policy managing the supply of health care providers in the United States. Apodaca (2007) and Runy (2009) cautioned against the addition of such a policy, stating that disparities continue to exist in the United States because the influence that existing health policies have on the daily practices and the supply of health care providers remain underassessed and misunderstood. As explained by Grumbach (2002) and Runy (2009), little is known about the actual impact health

policies have on provider practice, and how these contribute to the statistics in disparities in access. Policies increasing the number of available health care providers and the number of insured individuals in the United States have not translated to significant reduction in the levels of disparities in access (Runy, 2009).

The Centers for Disease Control and Prevention published its Health and Disparities and Inequalities Report (CHDIR) in , 2011. This report highlighted the disparities in health care access in the US, though unacceptable were correctable. One of the findings in the CHDIR report was the increasing statistics in disparities in access to health care services for both individuals with and without health insurance coverage (United States Department of Health and Human Services, 2011). Despite progress made in increasing the number of practicing health care providers, health care facilities, and the number of insured individuals, the report states that these have not resulted in eliminating much of the disparities in access (United States Department of Health and Human Services, 2011).

There were two purposes for conducting this research. The first goal was to identify some of the major national health policies that have been developed and enacted in the United States specifically to improve access to care, and to evaluate their effect on the practices of primary care providers. The other goal of the study was to determine the relationship that exists between these policies and disparities in access to health care services. The literature review shows the attempts to improve access to health care providers, the inadequacy in evaluating the effectiveness of health legislation, a reflection

on historical health legislations, and a discussion on current literature on legislation and the health care provider workforce.

The Literature Review Process

The search process to ascertain scholarly resources on health care legislation, primary care providers' availability and supply, and disparities in access in the United States used several databases, works by key authors, and organizational websites. The database and database search tools used for this search were: Academic Search Complete, Business Source Complete, CINAHL, Cochrane Database of Systematic Reviews, Health and Psychosocial Instruments, Health Source, Google Scholar, JAMA Online, MEDLINE, NHS Economic Evaluation, Nursing & Allied, Ovid Nursing articles, Policy File, ProQuest, PubMed, Sage, and Science Direct, were used. Literature from the U.S. Department of Health and Human Services, specifically including the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Healthy People, and the National Institute of Health (NIH) were also reviewed. I also used several databases providing access to peer-reviewed journals such as Health Affairs, National Center for Biotechnology Information (NCBI), and the *New England Journal of Medicine*, plus websites of organizations such as The Commonwealth Fund, The Henry J. Kaiser Family Foundation, and The Robert Wood Johnson Foundation, as well states' Departments of Health, and the Florida Council of Advanced Practice Nurses political Action Committee websites.

A major goal of the literature review was to identify and synthesize recent information and data concerning issues affecting U.S. primary care providers' professional practices, with a specific focus on policy-related issues. Several professional publications were review to understand health care legislation, its scope, and its impact on health care delivery. Search terms used included, *barriers and opportunities in accessing health services*, , *future predictions of health care workforce*, *health care access*, *health care delivery challenges*, *health care legislation, health care policy*, *health care provider workforce*, *health care reform*, *improving access*, *Patient Protection and Affordable Care Act*, *physician workforce*, *primary care provider*, *primary care supply*, *shortage of primary care providers*. Combined search terms included, *Affordable care act and primary care providers*, *governance and health care supply*, *health policy and physician workforce*, *policy development and implementation process, policy evaluation and policy analysis*, *restrictions and expanding health care provider workforce*, and *reimbursement methods and provider satisfaction*. Limited research on many of these topics were available for the past five years. The date range was expanded to analyze the history of health reform and allow a reflection on previous legislation.

Topics Reviewed

This literature review provides a reflection of some policies that were implemented to expand access to health care services in the United States over the last three centuries. It begins with the identification and reflection of a few major health care policies. It also explores the basic tenets of health policy development and analysis, and how these may have contributed or continue to contribute to the design and current state

of the US health care delivery system (Kraft & Furlong, 2010). The review then focuses on these health policies and their possible relationship with disparities in health care access.

The literature review documents research on access to health care services (Maxwell, Cortes, Schneider, Graves, & Rosman, 2011), improvements in access in American communities (Sekhri, Feachem, & Ni, 2011), the expansion of existing health policies, and the development of new ones (Abood, 2007). Despite a wealth of literature focusing on patients' access to health care services, little has examined the impact health care legislation has on the daily practices of primary health care providers (Brock, 2012). The focus of this study was to evaluate the role these policies may play in contributing to the prevalence in health care access disparities.

This chapter also focuses on literature related to the conceptual framework of health politics and planning, policy development and evaluation, and health care access. In addition, recent data on health care access in this country was also reviewed. The literature review also explores the challenges and complexities in delivering health care services in this country. As health care delivery is centered on access, quality, and cost, advances in one area often do not result in improvements in the others. Health reform in its purest sense should improve all areas not only for health care consumers, but also health care suppliers and providers. Although policymakers develop health policies often with a clear intent, this review will find that these policies sometimes produce unexpected and often ignored consequences.

Policy Analysis

Policy analysis examines the issues and the development of recommendations that will create solutions to correct the issues (Bennett, Corluka, Doherty, & Tangcharoensathien, 2012). Policy analysis in health care provides the structure for synthesizing the issues (Bennett et al., 2012). Considered to be a plan of action, health care policymakers and stakeholders work together to create a product (the legislation), which becomes the response to the problem (Bennett et al., 2012). One of the major deficiencies in the health care delivery system in the US according to Bgeman (1950) and Goodman & Fisher (2008) is the inability of many Americans to access the services of health care providers. For many years, health care policymakers interpreted programs increasing the supply of health care providers such as medical loan forgiveness and attractive repayment plans, and the expansion of medical school programs as adequate health care provider expansion measures (Bgeman, 1950; Goodman & Fisher, 2008). For many decades, health care policymakers and other stakeholders forecasted improved access primarily due to anticipated surpluses in physician supply (The Commonwealth Fund, 2009). According to the Cooper (2004), "these much heralded surpluses never materialized, and a growing body of data and opinion now point in the other direction, a shortage in the number of practicing health care providers" (p. 704). A review of the literature highlighted local and statewide policy decisions which would have supported the view of adequate numbers of health care providers (The Commonwealth Fund, 2009).

According to Reese (2011) and Sheikh (2012), the inequitable distribution of health care providers, uneven performance measurement and satisfaction tools for HCP,

the lack of motivated health care workers, as well as a severe shortage of PCP, are some of the indicators that improving access to health care providers continues to be a major problem for health care stakeholders. According to Sheikh (2012), a global crisis will continue to exist as long as health care providers are unable to meet the demand for healthcare services. The identification of these concerns is the first step in developing the solution. Derose, Gresenz, and Ringel (2011), stated that in order to reduce disparities in health care, it is important to first understand why there are inequities in accessing the services of health care professionals.

Mittman and Sullivan (2011) stated that the limitations providers face in their practices contribute to disparities in access. The ongoing discussions among policymakers and health care stakeholders are evident, and there is a consensus that many health care policies are considered to be only band-aids (Mittman & Sullivan, 2011). These coverings unfortunately are no longer adequate, and legislators must consider creating a health care delivery system that is capable of expanding access to providers' services (Mittman & Sullivan, 2011). Improving access to care for health care consumers and reducing disparities require a system that does not consequentially restrict suppliers (Currie, 2013). Therefore, any future health legislation should seek to benefit both the utilizers and suppliers of health care services.

The US health care delivery system though complex, has at its core the relationship between health care provider and patient (Buchan, 2010). Although the US health care delivery system has historically been physician driven, patients' ability to seek care and their outcomes are impacted by non-physician related factors such as

financial, organizational, and structural health care policies (Buchan, 2010). While the author highlighted efforts such as increases in the number of insureds in the population or expansion in medical training programs; there is a lack of favorable outcomes in increasing the accessibility to health care providers (Buchan, 2010). After examining limited research on these benefits, Buchan (2010) stated that the lack of the stability and consistency in the practices of health care providers contribute to a broken health care system. After reviewing the literature on the current state of the US health care system, it is evident that any attempts at real reform should begin with an examination of health care policies enacted within the past three centuries and their effect on the health care provider practice.

Reflection on Historical Health Legislation

Efforts to improve health care delivery in the US have been long and have taken various approaches. As put forward by Abood (2007), the development of health legislation has been a contentious issue that has been sharply divided along party lines. As elected political representatives and other health care stakeholders proposed and developed different health legislation (Hirshfield, 1970), the approach remained consistent, with only minor modifications (Clark, Field, Koontz, & Koontz, 1980). According to Hirshfield (1970), health care legislation aimed at improving access to care remained focused on the most vulnerable in our population; the indigent and the elderly. Decades later, both the federal and state governments have developed legislation focused primarily on the unemployed, underemployed, and elderly citizens (McIntyre, Thiede, & Birch, 2009). However, despite the somewhat active input from health care providers in

the development of health care legislation (Abood, 2007), the effect of many of these legislation on the health care workforce remains understudied and often ignored (Brock, 2012).

Major Federal Legislation

Early Health Legislation: Pre 1800s

According to Harding (1937), the first record of health legislation improving access to health care services in the US was in 1798. This government health care plan known as the United States Marine Hospital Service is described as the genesis of the modern health care system in America (U.S. Marine Hospital, n.d). The first health care legislation of this facility was the Act for the Relief of Sick and Disabled Seamen established in 1798 which was enacted to provide health care services to service men and women, and facilitated research, hygiene and science-based medical treatment (U.S. Marine Hospital, n.d). As more marines were exposed to communicable illnesses, heat and cold related sicknesses, and accidents; expanded access to health care services were provided through the funding of wage deductions (U.S. Marine Hospital, n.d).

According to Harding (1937), this health care legislation was an important foundation in expanding the access of health care providers, particularly primary care physicians. Through a mobile workforce stationed where the service was in need, physicians were ready to serve marines, and other seamen, as well as immigrants at the ports of entry. In the early years, physicians were not appointed to a given hospital, but to the Service as a whole. Despite its intent and benefits, this health access legislation was constantly criticized (Harding, 1937). Some of the issues cited by the author included the

lack of coordination in fighting communicable diseases between health care providers and other health care stakeholders, constant disease outbreaks, overcrowding in medical facilities, and the expanded and overbearing work load of physicians (Bliven, Cowley, Lovett, Soule, & Young, 1938).

Years after the implementation of this health legislation, Harding (1937) reviewed how this legislation may have impacted access to health care services. Physicians in particular complained about low remuneration, and their lack of participation in efforts to further develop the system (Nyweide, Anthony, Chang, & Goodman, 2011). While marines and other military personnel were dependent on this much needed care, this health policy inadvertently restricted how primary care providers delivered services, particularly by discouraging physicians through strict regulations (Bgeman, 1950).

Subsequent Amendments

Prior to this becoming the United States Public Health Service and later a part of the United States Department of Health and Human Services (USDHHS), this health care program was known for its bureaucratic fiscal neglect (McLaren, 2007). As additional legislation were implemented over the years, McLaren (2007) believed that these were done to meet political needs rather than the medical or health needs of patients and health care providers. The author stated that despite subsequent legislation such as the Uniformed Services Health Professions Revitalization Act of 1972; trained primary care physicians were in short supply to meet the needs of the marine and the military. Physicians who worked for this facility were frustrated with the legislation (Clinton,

1998), and military personnel and their dependents began to highlight the inadequate access to PCP and facilities (McLaren, 2007).

Health Care in the 1900s

Fullerton (1996) examined the politics of health policies in the US over the years. Between 1910 and 1940, Presidents Roosevelt and Coolidge proposed health legislation that would contribute to improved access to care for many Americans (Fullerton, 1996). These policies as presented by the author were the first attempt of national health reform, primarily as a response to increasing health care costs, and the increasing demand for health services by citizens (Fullerton, 1996). What was omitted from this peer-reviewed perspective was the lack of focus on the impact these policies have on the daily practices of health care providers. As necessary as improved access was for citizens, many of these proposed legislation were blocked by health care providers, and with good reasons (Bliven, Cowley, Lovett, Soule, & Young, 1938), and viewed by many other stakeholders as primarily political allegiance buy-ins by health care consumers (Fullerton, 1996).

The literature review failed to identify any analysis or review of the impact this legislation and its subsequent amendments have on expanding the availability of health care providers. Failing to understand the specific reasons PCP were reluctant to deliver services not only affects the effectiveness of this legislation, but also the development and assessment of future legislation (Fullerton, 1996).

Initial health reform: 1950s – 1960s.

The 1950s saw the amendment of the Social Security Act which was originally passed in 1935. The Act when initially passed focused on states providing assistance to

elderly individuals, unemployment assistance, aid to families with dependent children, child and maternal welfare, public health services, as well as blind Americans (DeWitt, 2010). What was omitted was the National Health Insurance (NHI) element previously proposed by President Roosevelt (DeWitt, 2010). When amended later, the Social Security Act became the main payer to nursing home, and improved access to care for the poor (DeWitt, 2010). Despite opposition by doctors (DeWitt, 2007), the Act and its subsequent amendments impacted health care delivery and access to health services. The primary basis for the opposition as explained by the author was stakeholders' (primarily physicians and physicians' interests groups) views that this as social insurance (DeWitt, 2007).

In 1965, further amendments were made to the Social Security Act. Despite strong opposition primarily from the American Medical Association (AMA) (Goodman & Fisher, 2008), Medicare and Medicaid were passed by Congress and President Johnson. According to Berkowitz (2008), this physician interest group was primarily concerned about the role the government would play in establishing physicians' fees; primarily reimbursing hospitals, and the "usual and customary" fee-for-service for doctors (p. 88). The author suggested that this health care legislation's (especially as it relates to Medicaid) has negatively impacted the daily practices of physician and other health care providers, and encouraged future studies to examine the effect (Berkowitz, 2008).

A review of the literature discovered a substantial amount of information on the payment practices of Medicare and Medicaid and their impact on access to physician

services, but limited resources on the daily practices of health care providers (McLaughlin, 2005). Medicaid's reimbursement time affects physicians' willingness to accept new Medicaid patients, as well as terminating care to existing Medicaid patients (Cunningham, 2009). According to Cunningham and O'Malley (2009), increases in reimbursement rates do not increase physicians' participation in Medicaid. While increasing fees has often been the primary method used by policymakers to expand the availability of health care providers delivering health services to Medicaid enrollees (Cunningham & O'Malley, 2009), the authors cited a study conducted by the Robert Wood Johnson Foundation that supported the finding that the reimbursement process is a major deterrent, as well as the administrative burden the Centers for Medicare and Medicaid Services (CMS) place on health care providers. Despite possible corrective methods that could be used to increase the willingness of health care providers to see Medicaid enrollees, for example partial capitation, health insuring organizations, as well as savings for reduced immunizations (Welch, 1990), it remains difficult to implement a one-size fits all resolution for expanding access to primary care providers in states' Medicaid programs.

Similar issues exist with Medicare. Continued Medicare physician payment reform has lowered Medicare patient revenue for many physicians (Schoenman, Hayes, & Cheng, 2001). In this research article, the authors highlighted the increasing dissatisfaction and growing trends in physicians' dissatisfaction for Medicare fee-for-service health maintenance organizations (HMOs), preferred provider Organizations, (PPOs) and other private fee-for-service providers (Schoenman, Hayes, & Cheng, 2001).

Webb (2010) cited an archived report published by JAMA, focusing on the inequity in Medicare reimbursement by most primary care physicians who responded to a national survey. Apodaca (2007) examined the inequity in Medicare reimbursements to providers. Physicians who participated in pay-for-performance schemes are rewarded with bonus incentive payments if the criteria are met, and those who are non-participants often face Medicare cuts (Apodaca, 2007). The recent fiscal cliff situation at the beginning of 2013 in the US also presented the potential impact Medicare policies have on the practices of health care providers (Zimlich, 2012). According to the author, Medicare reimbursement rates could have been reduced by an estimated 27%, which could impact not only affect Medicare patients' access to hospitals but also primary care physicians (Zimlich, 2012). While this was avoided, this current legislation's payments structure to primary care providers, and the political climate continue to impact the types of services provided by health care providers (Hasson & Hemphill, 2013).

Latest healthcare reform: 2010 and beyond.

In 2010, President Obama signed into law The Patient Protection and Affordable Care Act (PPACA). While the Act addresses the future role of public programs such as Medicaid and Medicare, improving the quality and efficiency of public health services, revenue provisions; the focus of the Act for this exercise is the goal to expand access to primary health care services for citizens (Healthcare.gov, 2011). As the entire Act is gradually being implemented there are many uncertainties on the impact this will have on access to health services and providers (Rosenbaum, 2011).

The PPACA will enable many uninsured Americans to obtain health insurance coverage (Stephens & Ledlow, 2010). While this is a good step, Currie (2013) suggests that is just the beginning of the work. Expanding coverage implies increasing demand for health services. The challenge for health care legislators is to figure out how the present health care system can best treat these additional patients (Frellick, 2011). The challenges discussed earlier for Medicaid enrollees remain a major concern for this health care legislation as it promises to expand state Medicaid programs (Currie, 2013).

On the other hand, Iglehart (2011) discussed the provisions in the Act such as increased funding for the training of health care professionals and improvements in Medicaid expansion reimbursement rates that can expand the availability and access to primary care providers. According to the author, the use of other health care providers such as advanced nurse practitioners and physician assistants as primary care providers can expand the overall supply of HCP (Iglehart, 2011). Interestingly, this can also lead to what the author referred to as a "turf-war", as the scope of practice of HCP may limit any potential progress proposed for expanding the delivery of primary care services (Iglehart, 2011). Its impact on health care supply is yet to be seen but both supporters and those who oppose the Act agree that this will have an effect on health care delivery, and the potential exist to add further strains to a fragile health care provider workforce.

State Legislation Expanding Access to Health Care Services

Calls for state policies aimed at improving access to health care services date back to the early 1900s (Rosenthal, 1972). According to Rosenthal (1972), states have been the laboratories of innovation, due to the demise of health reform at the federal level. Many

of the state initiatives have been models for universal health coverage, but majority of these efforts have been defeated with the influence of health stakeholder groups such as the AMA and other health care providers' interest groups, labor groups, and pharmaceutical groups (Bliven, Cowley, Lovett, Soule, & Young, 1938).

Neiditz and Fields (1993) examined the early initiatives undertaken by several states. State health policymakers are closer to local health care stakeholders and often are better able to handle the complexities of health reform within their specific states (Neiditz & Fields, 1993). The authors discussed state attempts as grass root initiatives which are less broad and more direct than federal initiatives (Neiditz & Fields, 1993). State policymakers work closer with heath care consumers, providers, and other local stakeholders in order to develop more effective local health policies (Neiditz & Fields, 1993). While the authors discussed this as a benefit, Riley (1995) suggested that these are not always beneficial. The close relationships often promote the interests of one stakeholder group over another, and often have resulted in failed attempts at true health reform (Riley, 1995). This view supports the findings provided by Bliven, et al. (1938) that groups such as the AMA have been successful at defeating state initiatives, especially when these legislation potentially could impact the future reimbursement rates their members will receive.

In 1939, California proposed compulsory health insurance for residents earning below $3,000 annually (Belshé, 2011). This led to the first pre-payment plan for health care providers' services in the United States, known as The California Physicians' Service (CPS). According to Belshé (2011), AMA encouraged the expansion of this plan

to other states, with the goal to capture support for its own plan. To date, California has one of the highest degrees of managed care penetration in the country (Grumbach, Coffman, Young, Vranizan, & Blick, 1998). The authors presented the notion that physician-supported legislation aimed at expanding access at the state level are more frequently enacted compared to national initiatives (Grumbach, Coffman, Young, Vranizan, & Blick, 1998). While on one hand this is beneficial, the influence of one group can significantly impact the type, format, and goal of the legislation, as well as limit the analysis and review that can be performed on the effectiveness of the policymaking process and the policy itself.

As California became a model state in improving access to care, an analysis of physician availability and types of provider practice was done by Grumbach, Coffman, Young, Vranizan, and Blick (1998). When compared to national figures, California had an ample number of specialist physicians practicing between 1980 and 1985 (Grumbach, Coffman, Young, Vranizan, & Blick, 1998). Like many other states in the country, California has an imbalance between specialist HCP and primary care providers (Grumbach, Coffman, Young, Vranizan, & Blick, 1998). The authors highlighted that over 90% of the HCP educated in the state remain there to practice. As the most populous state in the US, efforts are needed to increase the supply of PCP within the state (Grumbach, Coffman, Young, Vranizan, & Blick, 1998). A published report by the AMA indicated that California has the highest representation of active members in the American Medical Association (American Medical Association, 2011). While recent literature was not obtained showing a positive relationship between the availability of

health care providers and AMA supported health care policies; previous research provides evidence that health legislation supported by this physician interest group often is supported by many of its members and has resulted in fewer restrictions on the scope and extent of health services offered by health care providers (Robinson & Casalino, 1995). Another finding put forth by the authors is the AMA's effectiveness in preventing the implementation of any sort of universal health coverage, due to its lack of support (Robinson & Casalino, 1995). As the authors suggested, there may be a relationship between the effectiveness of health policies and how health care providers deliver health services (Robinson & Casalino, 1995).

In 2003, the Dirigo Health Reform Act was passed in Maine to establish universal health coverage, via an expansion of not only public coverage, but also private-sponsored coverage (Rosenthal & Pernice, 2004). According to a report published by The Commonwealth Fund (2011), this legislation contained provisions that expand access to care, improve the quality of health care offered to residents in the state, as well as contain costs. Limited literature exists on the impact this legislation has on the practices of Maine's health care providers.

In 2006 several states passed health care policies improving access to care for residents. Maryland passed the Public-Private Partnership for Health Care for All, as well Vermont passed the Health Care Affordability Act of 2006 (Sekhri, Feachem, & Ni, 2011). Massachusetts in the same year passed health care reform legislation (Gruber, 2008), an initiative mandating new-universal health care coverage (SteelFisher, et al.,

2009). Since then, the state leads the nation in the lowest number of uninsured residents in the country.

SteelFisher et al. (2009) analyzed Massachusetts physicians' views on this health care legislation several years after its implementation. Three categories were examined in the study; the support of the legislation by physicians, the effect of the legislation on their practice, and the effect on health care across the state (SteelFisher, et al., 2009). Approximately 40% of the 2,135 respondents believe that there is a negative impact on their practice due to the administrative burdens of the legislation (SteelFisher et al., 2009). Less than 5% of the physicians indicated that the legislation directly restricted access to their services (SteelFisher et al., 2009).

Policies expanding health insurance coverage for residents in these states led to an increase in the demand for health care services, which unfortunately has not been met by an equivalent increase in health care providers (Collins & O'Brien, 2011). According to the authors, a survey conducted in 2008 after Massachusetts' health care policy was implemented, indicated a shortfall of primary care physicians and general internists across the state (Collins & O'Brien, 2011). In a survey conducted by the Center for the Advancement of Primary Care (CAPC), results showed a current shortage of primary care physicians in Central Massachusetts, and physician retirements could increase the number of primary care physician vacancies within the next five years (Collins & O'Brien, 2011). Some of the solutions to eliminate the current and anticipated shortage in primary care providers are increasing the reimbursement rates paid to PCPs, tuition forgiveness programs, and expanded primary educational programs (Collins & O'Brien,

2011). What was missing however from this analysis was the importance of reviewing the direct and indirect impact this legislation may have on the practices of Massachusetts' health care providers.

Blumenthal (2004) examined the health care provider workforce and efforts implemented to expand its size. Historically, federal policies related to the supply of physicians are only derived after receiving evidence of the distress of the public, professional consensus, or both (Blumenthal, 2004). States such as Florida and Texas built medical schools and expanded education programs for nurse practitioners and physician assistants as policymakers anticipate shortages in the supply of primary health care providers (Blumenthal, 2004). While legislation expanding the physician supply is welcomed, it may take many years before these new health care providers are added to the HCP pool (Iglehart, 2009). However, according to Cunningham and O'Malley (2009), Currie (2013), and Iglehart (2009); increased enrollment in health education and teaching facilities, has not always translated to improved access especially in primary care, and for Medicaid enrollees.

Legislation Initiated by Other Health Care Stakeholders

Efforts aimed at expanding health care access have also been initiated by other non-governmental stakeholders. Many of these policies have been centered on the development or expansion of health insurance coverage for individuals. Blumenthal (2006) reviewed the emergence of employer sponsored health insurance in this country. Prior to 1910, employers especially those in the mining, lumber, and railroads industries, would develop private and voluntary programs that often prepay doctors fixed monthly

fees to provide medical care to employees (Blumenthal, 2006). After the depression in the 1920s, when access to health services was restricted, the Kaiser Foundation Medical Care Plan began arranging for voluntary salary deductions to cover workers and their families' health care needs; which was later expanded in 1945 (Blumenthal, 2006). Other employers soon after began to offer health insurance coverage as in incentive for employment.

Blumenthal (2006) primarily attributed this to two events. The first was President Roosevelt's decision not to pursue universal health coverage after his election victory in 1932, as well as rules enacted by the federal government beginning in the 1940s on the treatment of health insurance deductions for tax purposes (Blumenthal, 2006). Since then, employer-sponsored health insurance has grown and to date is the primary type of insurance coverage for many Americans.

Organized Medicine Takes Shape

In the early 1900s, doctors began to organize within their profession (Matell, 1993). Blumenthal (2004) examined the trends in physician supply. In 1901, AMA had approximately 8,000 physicians. Ten years later, the number was over 70,000, which amounted to half the physicians in the country (Blumenthal, 2006). Several writers identify this as the period of organized medicine. In 1934, the AMA adopted principles to protect physicians' right to set rates based on patients' income, and to supervise voluntary insurance; as well as declaring it unprofessional for doctors to seek profits in practicing medicine (Matell, 1993). Yet despite this, disparities in access persisted.

According to Matell (1993), inadequate access to health services by patients placed HCP under fire. The AMA's membership by then grew significantly, and the organization became the principal voice for the medical community (Matell, 1993). By becoming an advocate of change, the AMA was committed to the expansion of access to care, controlling health care costs, improving the quality of care, as well as preserving the freedom of choice to select the types of insurance coverage and health services (Matell, 1993). By working with local health care policymakers as well as Congress, initiatives were proposed that led to the development of new or updated health legislation.

As the AMA membership grew to over 300,000 in the early 1990s, this organization lobbied for the creation and expansion of alternative health plans (Hansen-Turton, Ritter, Rothman, & Valdez, 2006). As the number of employer-sponsored and other managed care health plans increased, doctors were unable to voice any possible grievances with the restrictions placed on them by these plans' insurers (Schwartz, 1994). According to the author, the then president of the AMA believed that these restrictions were impacting the supply of health care services to patients. This led to the group's support of anti-trust bills that would limit the restrictions of health insurers, and allow the implementation of less restrictive health insurance coverage for patients (Schwartz, 1994). One of these health plans was Health Access America (Burris, 1993), which was often referred to as the AMA's plan for health reform.

Another effort of the AMA in influencing expanding access was the development of health policies that provided malpractice immunity to doctors working in free clinics, as well as guidelines expanding the donations of medications (Reese, 2011). Similarly, as

physicians became displeased with many of the organization's efforts, other health care providers' membership groups became influential in health policy development and advocacy (Romano, 2006). What the literature review has shown is that these physicians' membership groups are often influential in the development and passage of health policy. Health policymakers have actively sought the support of these groups in developing health legislation (Reese, 2011). While credible research does not exist on the effect of these physician-sponsored and supported health legislation on the supply of health care providers, Reese (2011) indicated that policymakers recognized that the support of these groups is critical to the development, implementation, and effectiveness of the policy. Romano (2006) additionally stated that when physicians' views are represented in the policymaking process, there is often an improvement in the supply and delivery of health care services across communities in the US.

Current Literature on Legislation and Health Care Provider Workforce

The search for literature on the availability and practices of health care providers was done to identify disparities in access in the United States. Much of the literature highlighted the disparities as, the shortage of primary care providers especially in rural areas, the disproportionate portion of specialist HCP to PCP, and the different reimbursement practices of payers. What was common in the literature however, was the policy implications that needed to be researched.

In examining the health care staffing position, Isgur (2008) examined the data on the numbers of practicing health care providers. According to Isgur (2008), "the health care industry in the US is in the middle of a full-blown workforce crisis" (p. 18). The

crisis is exacerbated by the inability to attract and retain health care providers(Isgur, 2008). An aging population and HCP workforce, along with increasing connections between reimbursement and quality of care, as well as the changing dynamics in health care delivery are some of the reasons cited by the author for these shortages. While the author proposed intermediate fixes such as establishing performance-based metrics, several health policies underlie the disparities in supplying health care services. A recommendation Isgur (2008) proposed is future research analyzing how legislation affects the availability and overall supply of health care services, in order to assist leaders in health care in improving staffing of health care facilities.

As seen in the earlier section of the literature review, both the federal and state governments have grappled with ways of increasing the availability and distribution of health care providers. Although individual factors such as practice patterns and locations must be considered, system factors such as policy development and implementation affect the distribution of HCP (Ricketts, 2005). Ricketts (2005) stated that health legislation developed by the Centers for Medicare and Medicaid Services, directly and indirectly impact the availability and distribution of HCP. If this argument is indeed true, the author believed disparities in the supply of health care services are as a result of a fragmented health care system and an ineffective legislative development and analysis process. The author expressed belief that credible research focusing on the impact of policies on the maldistributions is needed to address the current disparities, and also in the development of future legislation.

In attempting to assess the readiness of the US health care provider workforce in confronting the burden of chronic disease; Bodenheimer, Chen, and Bennett (2009) reviewed the primary and public health workforce in the country. The future projections in chronic illnesses the authors believed will only further highlight the disparities seen not only in physician types, but also the lack of multidisciplinary teams (Bodenheimer, Chen, & Bennett, 2009). What the authors explained is needed is not more PCP or specialists, but instead policy reform. Some of the recommendations proposed were national policies limiting the number of future specialists, reform in reimbursement methods, as well as a legislated national workforce policy that can accurately estimate the demand for health services (Bodenheimer, Chen, & Bennett, 2009). While these were not specifically assessed in this study, the recommendations are also supported by Cooper and Aiken (2006) in their research article.

Staiger, Auerbach, and Buerhaus (2011) evaluated some of these recommendations in Massachusetts several years after the state's health care reform. Prior to 2006, growth in HCP employment in the state lagged behind the rest of the US (Staiger, Auerbach, & Buerhaus, 2011). Subsequent to the reform, the HCP workforce in Massachusetts remained almost the same as the three years leading up to the reform (Staiger, Auerbach, & Buerhaus, 2011). According to the authors, despite some measure of payment reform in the state, as well as efforts that were put in place to meet the increased demand for health care; the size of the physician and health care provider workforce remained at the same levels prior to the state's health care reform (Staiger, Auerbach, & Buerhaus, 2011). The authors stated in their conclusion that legislation such

as the PPACA will have to address the effectiveness of existing health access policies if these disparities can ever be addressed. Unfortunately, many argue that the legislation lacks this and so research is needed not only to enhance the policy development process but also the evaluation of the direct and indirect consequences of these policies.

Pardes (2009) examined the health reform proposals presented to Congress for legislative action. The main omission the author cited was the soon-to-be critical shortage of doctors facing the nation (Pardes, 2009). While many were focused on reducing and eliminating health care disparities for health care consumers, few proposals were presented to develop legislation that will address any possible restrictions health care providers face as a result of health care policy requirements (Pardes, 2009). Pardes (2009) suggested that one of the main reasons for disparities in access to health care providers was the income disparities between specialists and PCP; in that specialist HCP are able to charge more and pay less in costs compared to PCP. While this literature presented areas that needed to be reformed such as reimbursement procedures and rates, raised residency caps, as well as malpractice reform; the author failed to examine how these could actually enhance primary care providers' willingness to provide health care services.

Jacobson and Jazowski (2011) examined this further after the passage of the Patient Protection and Affordable Care Act (PPACA). The PPACA while welcomed, is expected to further strain the PCP workforce (Jacobson & Jazowski, 2011). The authors explained that if health care providers are not fully accepting of this new legislation, then these HCP can quickly become marginalized in the legislative process. The literature

while adding to research on the state of the primary care system, failed to identify what could be the direct causes of this marginalization. Agreeing with Pardes (2009) on the income disparities between primary care and specialist providers, Jacobson and Jazowski (2011) suggested that any additional legislation expanding demand for primary care services without adequate attention to supply could possible break the delivery of preventive care services (Jacobson & Jazowski, 2011). The authors claimed that this could be a disruptive change to the PCP system in existence, especially in rural and underserved areas.

Freed and Stockman (2009) examined the supply within primary care specialties. According to the authors, data on the shortages in primary care services are not entirely correct and are misunderstood (Freed & Stockman, 2009). There are several specialties in primary care services, and current and proposed legislation for primary care services often fail to address each sub-specialty within primary care (Freed & Stockman, 2009). For example, legislation aimed at expanding access to pediatric PCP, could have an opposite effect on adult PCP. A search for credible published research analyzing the impact of policies on primary care sub-specialties over the past 20 years did not produce any results. It therefore identifies that there is a gap in literature on the impact legislation has on primary care and its sub-specialties.

Wright (2009) explored the history of four rural health care programs across the US. Previously assessed by the National Evaluation of Rural Primary Care Programs, the author felt it was necessary to examine why only four of the original rural primary care programs remained sustainable while others which were assessed earlier did not (Wright,

2009). All the facilities faced similar issues such as community integration, organizational and structural flexibility, as well as a comparable number of available HCP. Wright (2009) stated that the sustainability of these and other similar health care organizations were primarily dependent on being able to accurately assess the needs of its workforce, and the factors that can impact how HCP practice. One of these was being able to understand legislation in its entirety and being prepared to make changes to the organization's operations or structure when needed (Wright, 2009). The study while providing health care facilities with recommendations of assessment, monitoring, evaluation, and modification if needed was completed using secondary data and secondary sources (Wright, 2009). The issue with this the author highlighted was the use of data that may not have been created for the purpose of organizational operations and sustainability (Wright, 2009). While the author discussed that these organizations' sustainability was linked to their leaders attention to the impact of legislation, there is no clear-cut evidence that being able to assess the impact health legislation will translate to an organization's long-term viability and ability to improve access to health care providers when needed.

LeClair (2011) examined some of the biggest problems in the Minnesota Health Care System. The two main issues identified by the author were the pricing model and the supply model of the delivery in health care services (LeClair, 2011). The author's emphasis was on the pricing model used by the state and its high cost, and an analysis of how these models are related were presented. According to the author, the Medicaid system in Minnesota is a broken model and the more procedures performed by health

care providers, the higher the costs are to taxpayers (LeClair, 2011). Unfortunately this did not transfer to higher reimbursement rates for health care providers, which has contributed to the frustration of many health care providers to not see Medicaid patients (LeClair, 2011). According to the author, PCP encounter difficulties in the state in how health care services are priced, and this then constricts the supply of health care services (LeClair, 2011). While other authors have supported this view, the author further recommended that research be done on the possible relationship between the availability of health care providers and the pricing models used in health care (LeClair, 2011). The author stated that the misunderstanding of this relationship has in part contributed to the development of less than satisfactory legislation (LeClair, 2011). The difficulty LeClair (2011) explained in forecasting and measuring health care supply is accurately identifying and understanding the main underlying factors. The author however, never identified these underlying factors; and while this may be the case in this state, it may be difficult to make generalizations in other states or types of health care facilities.

For many years, the Council of Graduate Medical Education (COGME) has been responsible for providing evidence that support the number, types and distribution of physicians (Deal, Hooker, Harrington, Birnbaum, Hogan, Bouchery, Klein-Gitelman, & Warr, 2007). One of the roles this group has adopted is guiding the development of physician workforce policies (Deal, et al., 2007). As the authors explained, previous models used in estimating the health care workforce have provided surpluses for several decades followed by unpredictable shortages (Deal, et al., 2007). The shift in the statistics according to the research's findings was primarily attributed to the failure of health

maintenance organizations (HMO) to limit specialty HCP as well as utilizing the assumption that increased economic growth would increase the demand for specialized care (Deal, et al., 2007). The authors examined the difficulties encountered in projecting the future workforce due to the inadequacies of the models used. The literature however presented the relationship between the demand for health services and the methods used to develop policies expanding access the health care providers (Deal, et al., 2007). While the focus of the research was on the rheumatology workforce, its findings support the inability to maintain equilibrium in the delivery of health services (Deal, et al., 2007). One of the main shortcomings is the failure of the models to incorporate the ignored or unknown effects that influences the PCP workforce. One of these ignored effects is the analysis of existing and future legislation, and how these impact the practice methods of PCP.

In order to address the issues in the health care workforce highlighted in the selected literature, research has to look at the origin or source of the issue rather than focus only on the symptoms (Sommers, Swartz, & Epstein, 2011). Many authors, policymakers, and other health care stakeholders identify the shortage in the health care workforce, primarily physicians, NP, PA, and other advanced health care providers. Previous solutions have led to the implementation of reimbursement policies, expanding medical schools and training programs, loan forgiveness, as well as redistribution of HCP. Despite these, shortages exists in the supply of health care services, and with the full implementation of the PPACA approaching, many suggest the need for analysis of health legislation on the health care workforce. This can improve forecasting models used

in evaluating the primary health care workforce (Hoerster, et al., 2011), and be more valuable in the evaluation of existing policies and the development of new ones (Sommers, Swartz, & Epstein, 2011).

Framework for Policy Analysis

Introduction

Health care research focusing on the demand and supply for health care services have used several different frameworks to conceptualize the factors that influence health care delivery and access to care. Most of these frameworks have focused on personal beliefs, health insurance coverage, demographics and other "individual-level" factors (Huicho, et al., 2010). Despite the credible amount of literature that exists on accessing health care services, non-individual-level factors have been missing from the frameworks used in assessing the disparities in the supply of health care services. In this section, the framework used in this study will be discussed. In order to understand the role of health care legislation in addressing disparities, their impact on the supply of health care services should be reviewed.

The purpose of this study was to identify and analyze the relationship between major health access policies and the delivery of health services by primary care physicians, and to gather their perspectives on reducing disparities in access. This study examined these legislation with the purpose of determining whether these policies are associated with the increased shortage in the health care provider workforce. In order to verify this, it was necessary to examine objectively, evidence that can be used in developing future health policy. As the study examined both historical and current policy,

the conceptual framework used is policy analysis and evaluation (Patton & Sawicki, 1993).

Benefits of Policy Analysis

In order to correctly identify possible problems associated with a particular health policy, the policy analysis process requires the researcher to divide the broad policy into elements that can be examined on an individual basis (Patton & Sawicki, 1993). The authors believed that the use of a systematic approach in analyzing these elements individually can resolve complex issues (Patton & Sawicki, 1993). Additionally, having more manageable sections or elements provides the opportunity to examine how these parts fit into or contribute to the overall problem. Patton and Sawicki (1993) suggested that examining each element of the problem individually can create more effective resolutions.

Policy analysis is reactive as it is done after the problem is identified (Patton & Sawicki, 1993). This provides the study with the opportunity to identify and examine unique aspects of the disparities in accessing health care services, with consideration given to both the causes and solutions to the disparities. As the study involves an examination of existing health policies, the analysis of the process should examine whether these legislation are as effective as initially hoped. As Dunn (2004) stated, critically examining past and present policy requires thorough analysis. In this study, evaluating current and past policy provided a critical analysis that may be used in future research, and appears to support changes in the development of health policy relating to access to care.

Patton and Sawicki (1993) contended that policy analysis has evolved over the years. Despite these changes, it provides a researcher with the prospect to collect and interpret data which can be used to develop potential solutions to the problem (Patton & Sawicki, 1993). The opportunity exists to examine alternatives to complex issues based on the data collected.

One goal of this study was to examine the impact of health legislation on supplying health care services in order to provide evidence-based support for future policy. The analysis of the data collected could provide health care policymakers with recent practical knowledge that can be used in the process of developing future policies. Dunn (2004) explained that the use of practical knowledge can be more effective in addressing these issues compared to the use of mere intellectual knowledge. As a retrospective evaluation was done, the approach will also incorporate program evaluation.

Benefits of Policy Evaluation

There are several steps involved in the policy analysis process (Patton & Sawicki, 1993). These include identifying the problem, establishing a criteria for evaluating the problem, identifying alternatives, evaluating these alternative policies, comparing these alternatives, and evaluating the implemented policies (Patton and Sawicki, 1993, p. 52-53). The benefit of using this process provides one with both a pre and post analysis of the policy issue. As stated by the authors, the policy analysis process is circular, as its final step should result in a return to the first, as it should be determined whether or not to continue the policy or make modification (Patton & Sawicki, 1993). The final stage as stated by Dunn (2004) provides support or lack thereof of the effectiveness of the policy.

Therefore, any intended result of a health policy should incorporate the effectiveness of the policy and any previous changes that were implemented (Dunn, 2004).

Policy evaluation also assesses how well a policy is performing (Dunn, 2004). Health policy must be evaluated to determine whether its goals are met. Before any changes are made in health care legislation, a pre-evaluation of existing policy should be done (Dunn, 2004). If for example the expansion of Medicaid is resulting in restrictions in the supply of health care services, then before any changes are made to Medicaid enrollment and reimbursement policies, a thorough evaluation should be done on the performance of the policy. Also, if the issue with legislation is its restrictiveness, the evaluation process should examine what contributes to these restrictions before attempts are made to remove these restrictions.

The Policy Analysis and Evaluation Process

There is no definitive process for analyzing and evaluating health policy (Patton & Sawicki, 1993). The authors recommended that instead of using a standardized or one-size-fits-all approach, the process of analysis and evaluation must be based on the nature of the problem (Patton & Sawicki, 1993). The steps identified by the authors should be tailored to the issue being analyzed, and is shown in Figure 1.

By beginning with the verification of the issue at hand, a researcher identifies the various perspectives of the problem held by stakeholders. Health care research in the US is often viewed separately from the perspectives of health care providers, consumers, policymakers, public health representatives, and other health care stakeholders

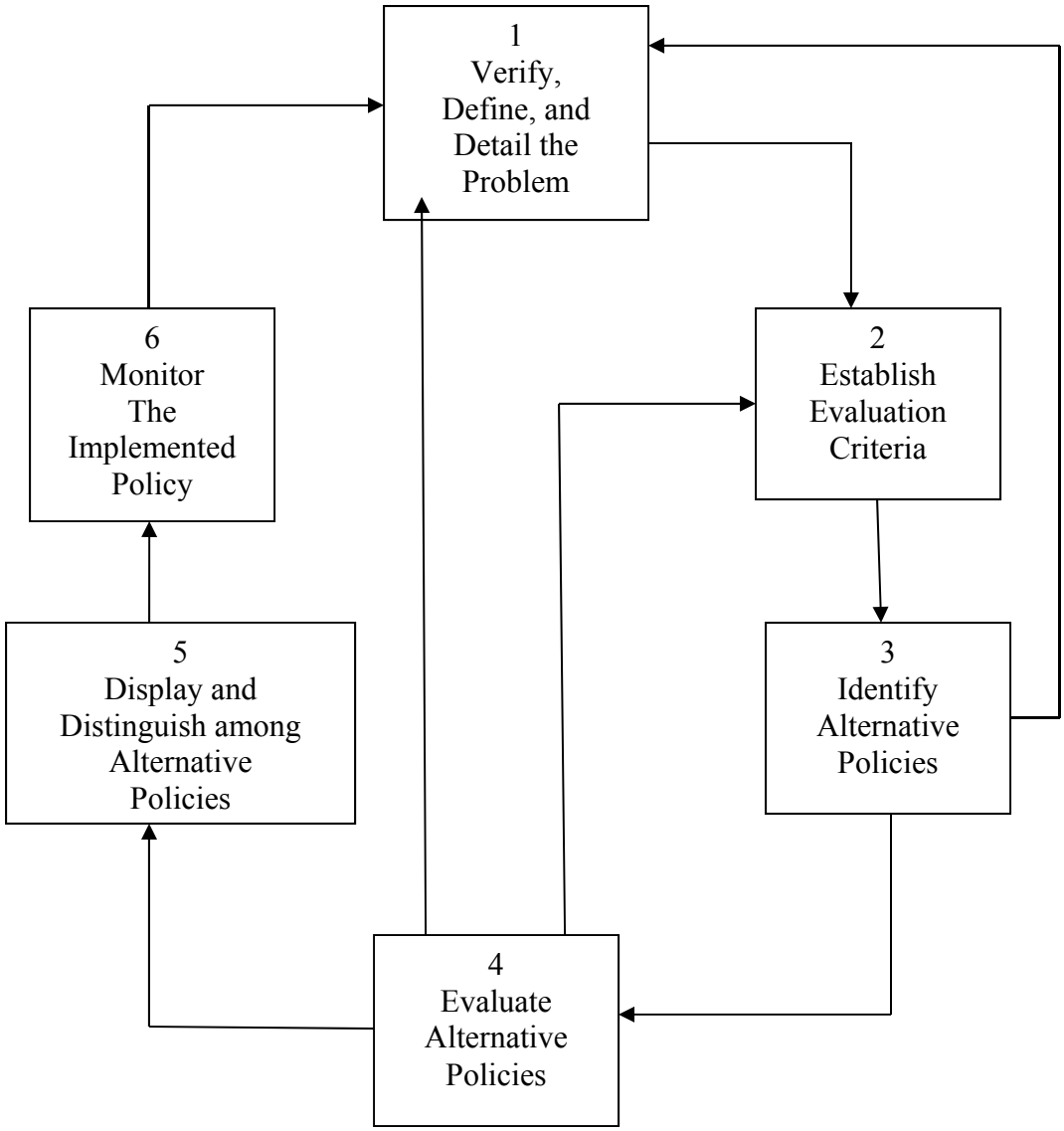

Figure 1. A basic policy analysis and evaluation process.
Source: Patton and Sawicki, 1993.

Each group may have a different perspective of the causes and solutions to improving the access to health services and reducing disparities in access. Therefore, each stakeholder's views should be incorporated to identify what the issue is that should

be resolved. Step 2 of the policy analysis and evaluation process is establishing evaluation criteria (Patton & Sawicki, 1993). The criteria often developed by policymakers should be established by all stakeholders and be relevant to address the issue (p. 58). Not only can this create the guideline to be used, but can be utilized in evaluating other stages such as the alternatives, once the collected data is being analyzed.

Stage 3 of this process identifies the alternative policies (Patton & Sawicki, 1993). With the input from stakeholders welcomed, there may be several alternatives revealed (p. 54). According to the authors, researchers should be able to also identify previously ignored issues that may be revealed during this step.

Once the possible alternatives have been identified, they should be evaluated as shown in step 4 in the diagram. The evaluation requires one to collect and analyze credible data in order to display and distinguish the alternatives, which is step 5 of the process (Patton & Sawicki, 1993). If modifications are then made to policy and these implemented, step 6 should evaluate and monitor the policy.

Application of Conceptual Framework to This Research Study

The recent Health Care and Disparities Report (2012) provided by the Agency for Health Care Research and Quality, as well as one of the Healthy People 2020 goals provide support that there is a shortage in the supply of primary health care providers across many communities. While other legislation have been implemented to increase the number of PCP primarily serving in rural communities, the anticipated effects have not materialized.

The review of the development of health policies expanding the size of the health care workforce provided inconsistencies primarily due to the lack of a national policy (Cooper & Aiken, 2006). As recent health policies have primarily been enacted at the state level, the variations or stem from the inadequacy of legislation to evaluate underlying factors both prevalent at the state and national levels such as a growing population or increasing prevalence of chronic illnesses in the population (Levesque, Harris, & Russell, 2013). As the authors suggested, this presents an appearance that having an inadequate and often unsatisfied health care provider workforce is acceptable in some communities (Levesque, Harris, & Russell, 2013). Additionally, these variations present challenges to policymakers, health care administrators, and other stakeholders who evaluate and enforce these policies.

If these health policies are not entirely effective and many suggest improving them, then the question arise whether these will be in the best interest of improving health care delivery. On one hand, some HCP view these policies as adequate and changes can create many uncertainties leading to further disequilibrium in the system. On the other hand, many suggest that future attempts to modify or develop new legislation are the only way to curtail rising health care costs, and improve access and quality. While both arguments have merit, neither opponents or proponents have provided sufficient evidence that refutes the other.

This study sought to examine the effect these health legislation may have on restricting the supply of health services delivered by primary care physicians. The literature provided a definition of the problem, disparities in health care supply, and the

lack of credible research valuable to future policy development. Also, several stakeholders' perspectives were provided on what these disparities are. The literature review provided a foundation that this research as well as future research could employ in developing, monitoring, and evaluating current and future health policy. This conceptual framework was used to understand how health care policy impacts the supply of health care services.

Mixed Methods Research

While access to health services has been a widely studied topic, most of the existing literature is centered on patients' access to care. Only a modest amount of literature exists on health legislation, and few have considered their impact on supplying health care services. While there are several qualitative and quantitative studies done on the health care workforce, and few studies done on evaluating health care legislation, there were no mixed studies done in the past decade that relate to any of these two variables. The use of mixed methodology in research can be both pragmatic and advantageous (Teddlie & Tashakkori, 2009). When researchers believe that the study is best supported by diverse sources of information from both open-ended and close-ended measures, mixed methods research can be highly effective (Creswell, 2009). In other health care research, a two-step approach was used; such as the administration of a survey, followed by open-ended methods of research. Teddlie and Tashakkori (2009) discussed that this method is often used to understand the population of interest first, in order to collect more information on the variables being studied.

There is increasing interest in the field of mixed methods research in health care research, and its emergence and practice is distinct from the two dominant paradigms; qualitative and quantitative. According to Creswell (2009), while mixed methods research can be complex, it is a unique research design which provides the benefit of both qualitative and quantitative data collection and analysis in one single study. Other proponents of mixed methods research such as Johnson and Onwuegbuzie (2004) have clearly stated that the time has come for researchers to use mixed methods research to bridge the division that exists between qualitative and quantitative research. This research design can produce results that are more superior to any of the two paradigms as it allows a researcher to use the strengths of both qualitative and quantitative methods (Johnson & Onwuegbuzie, 2004). Also, mixed methods research captures both inductive reasoning and deductive reasoning.

Researchers use an inductive approach to scientific inquiry by beginning with recorded observations that are then analyzed for themes or patterns (Patton, 2002). This approach allows these patterns or themes to be discovered without pre-determined assumptions of what the components are. From the data, interrelationships between variables are discovered and possible theories emerge. As is often seen in qualitative studies, the inductive approach presents a holistic approach, as the researcher is examining the perceptions of individuals at the present time (Miles & Huberman, 1994). This often is considered to be more realistic as the perceptions are understood to be changeable over time.

Quantitative research on the other hand often uses a deductive approach. Often beginning with a theory, researchers deduce relationships between variables (Creswell, 2009). With this approach, the theory can either be discredited or validated based on the results of the study. Researchers, who use this approach, determine the variables and potential relationships between them ahead of collecting the data. The theory used will not only guide the research problem, but also the method to be used, population of interest, as well as the type of data collected.

Both approaches when used together provide beneficial results. An inductive approach in a qualitative study and a deductive approach in a quantitative study, in any order highlight the power of mixed methods research compared to either a quantitative or qualitative research. Mixed methods also provide the benefits of identifying unknown variables directly from the population being studied.

Summary of Literature Review

With the recent advent of another health policy's full implementation, the importance of evaluating health policies' impact on the supply and availability of health care providers is important. The literature identified the present state of the health care workforce, the current shortage of primary health care providers, along with the anticipated future inadequate supply awaiting the expected increase in demand.

Minimal research has been done on the disparities in the supply of health care providers due to health legislation. The current and anticipated shortages in the primary health care workforce indicate that no effective policies exist in understanding and reducing disparities in health care supply. While the literature identified that the overall

health care workforce has been slowly increasing due to expansion in medical training and education, the lack of credible research on the possible negative impact health legislation may have on primary care providers supplying health services can potentially erode any positive results of these expansion efforts

Through a focus on policy development and implementation, more effective policies can be developed which can improve access to care for both health care consumers and suppliers. The discussion of the conceptual framework as well as research design for the study provided the foundation which was used to answer the research questions. Chapter 3 focuses on the methods that were employed in conducting this study and present justifications of why the mixed-methods approach was the most appropriate research design for this research study.

Chapter 3: Research Method

Introduction to Research

Research on disparities in health care access in the United States has traditionally focused on the availability and utilization of health care services by health care consumers. The scope of health care providers' practice and their availability are often ignored in studies examining the prevalence of health care access disparities (Bodenheimer, Chen, & Bennett, 2009). The current and predicted state of the U.S. health care workforce suggests that efforts are needed to address the disparities in access that currently exist, as well as improving the nation's health care delivery system (The Commonwealth Fund, 2009). With the passage and implementation of the Patient Protection and Affordable Care Act (2010), understanding the role legislation play in impacting the practices of primary care providers is critical.

This chapter provides a description of the research methodology used in investigating the role health policies play in restricting the services primary care providers offer and how these may be contributing to disparities in access in the United States of America. This dissertation study used a mixed-methods approach to assess the relationship that may exist between the supply of primary health services, disparities in access, and health care legislation. Additionally, this chapter discusses the research design, sampling procedures, population of interest, data collection and management of the research, participants' protection, and the presentations of results. This chapter provides both the researcher and the reader with an understanding of the possible

limitations health care providers face in the scope of their practices and the expectations these policies will have on disparities in access.

Research Design

A mixed-methods sequential explanatory design was used for this study. This chapter provides all the major parts of the research project, including the sample, measures, and methods of assignment, that were used to address the two research questions of the study. The primary goal of this study was to analyze whether these policies which were designed to improve the utilization of health care services may in fact be contributing to the prevalence of disparities in access, through a focus on policy analysis and evaluation.

According to Berman (2008), mixed methods are used extensively in behavioral, social, and health science research to solve practical research problems. Mixed-methods research has evolved to be a separate methodology that addresses research problems in a way neither qualitative nor quantitative research can (Bergman, 2008). As Teddlie and Tashakkori (2009) stated, while it is easy to think as mixed methods as collecting both qualitative and quantitative data, this methodology should be used in research that integrates both types of data into the research and its analysis.

Quantitative research employs both empirical methods and statements (Creswell, 2009). This approach is useful for collecting and analyzing large amounts of data, eliminating bias, and its accuracy (Creswell, 2009); its structured data collection, however, limits the ability of a researcher to gather information not specific to the instrument (Punch, 2005). In health care studies, quantitative studies confine the

likelihood of identifying the other factors or elements that directly or indirectly impacts the topic of interest (Punch, 2005). As a result, I did not select a strict quantitative research design because a rich detailed explanation of the reasons for these disparities would not have been obtained from only statistical analysis of the data.

Qualitative research on the other hand uses no-empirical methods and statements (Creswell, 2009). When a researcher utilizes qualitative methods, they are able to identify the themes and patterns in the data (Punch, 2005); doing so also provides the opportunity to further understand some of the data collected. A qualitative approach is often considered the ideal method to use in research that requires an understanding of more than the numbers or statistics (Miles & Huberman, 1994); however, it primarily offers subjective perspectives or views that may change rather quickly, which can restrict the replication of findings (Punch, 2005). While qualitative analysis on the other hand can provide this explanation, its lack of statistical inferences would have potentially reduced the study's credibility.

Mixed-methods research provides a researcher with richer findings, that are often more useful than the findings of either quantitative or qualitative research alone (Rocco, Bliss, Gallagher, & Perez-Prado, 2003). A survey instrument used in a mixed-methods study compared to one in a quantitative study often is more useful and more accurate in behavioral or health services research (Rocco, Bliss, Gallagher, & Perez-Prado, 2003). Many social-science researchers believe that several health topics should not be studied exclusively with either paradigm, but combining both quantitative and qualitative method allows researchers to utilize the strengths of both research methods (Terrell, 2012).

Because the goal of this research was to identify and analyze the possible restrictions PCP face in their practices, a sequential mixed method research design was used.

This research study utilized a survey and semistructured interviews with primary care providers actively practicing in the United States. As a result, the depth of the data collected depended on the participation of the primary care providers PCPs. A sample size of 15 participants will be used in the qualitative data collection, and 861 participants will be included in the quantitative data collection.

Role of the Researcher

The primary role of the researcher is to provide clarifications and explanations of the specific position based on established theories or previous researches (Rudestam & Newton, 2007). The researcher was the point of contact and source of clarification for the participating health care providers. In-depth interviews were conducted with the participants to gather explanations and responses provided in the survey instrument. Primary care providers responded to the survey developed in order to identify their understanding of the impact health care legislation have on their delivery of health care services, and the researcher's contact information was provided to participants if participants required further clarification. The researcher identified and solicited research participants, distributed and collected data, analyzed the responses of the participants, as well as identified themes or trends in the data. The survey was developed and delivered by mail to 1,050 primary care providers across the United States. As stated by Secomb and Smith (2011), the researcher or the interviewer must be capable of withholding personal perceptions and opinions.

Research Statement

While several health policies have been developed and enacted to improve access to health services for consumers, reducing disparities in access remains a major challenge for many consumers, policy makers, as well as health care providers in the United States. The impact these legislation have on the availability and willingness of primary care providers is understudied. The impact will be analyzed and the findings made available to participants and other stakeholders to be included in the development and evaluation of strategies improving health care access in the US. The goal was to determine the role these policies have in contributing to the prevalence of disparities in access to primary care physicians and services.

Research Questions

The purpose of this study was to answer two questions in order to analyze what impact health legislation have on the supply of services provided by primary care providers. The data obtained provided insight on measures that could be used to evaluate health policy as well as develop new ones. The research questions were:

1. What is the relationship between major health access legislation in the United States and the availability of primary care providers?

H_0: There is no relationship between health access legislation and the availability of primary care providers to deliver services.

H_1: There is a relationship between health access legislation and the availability of primary care providers to deliver services. The independent variable is health legislation and the dependent variable is the availability of health care providers.

2. What are primary care providers' perceptions regarding reducing disparities in access?

Context and Instrumentation

This study utilized two instruments to collect the data. The survey was the quantitative data instrument, and semistructured interviews was the qualitative data instrument. The use of both quantitative and qualitative data collection methods provides the opportunity to obtain an in-depth understanding of the topic of interest (Pitney, Mazerolle, & Pagnotta, 2011). Unlike other mixed methods research design such as the concurrent mixed method in which quantitative and qualitative data are collected and analyzed simultaneously, sequential mixed methods allows one set of data to be collected and analyzed at a time (Creswell, 2009). The rationale for selecting the sequential explanatory mixed method design over the initial qualitative design was to gain greater insights from the use of multiple data collection methods. Additionally Pitney, Mazerolle, and Pagnotta (2011) proposed that the use of multiple sources can improve the overall validity of the research's findings.

Health care disparities and policy development and analysis are complex topics. Improvements in both areas require continuous planning and evaluation. Any attempts to examine their effectiveness require strong analytical processes and evaluation research (Warner, Harrold, Allen, & Lyons, 2010). In explaining this point, the authors encouraged not only the use of theoretical strategies, but also real world applications (Warner, Harrold, Allen, & Lyons, 2010). Historically, disparities in primary health care supply have been addressed through proposals or policies such as expansion in nurse

practitioner autonomy, loan forgiveness, or revisions to the educational requirements (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013). Despite these expansion efforts, actions to reduce disparities, shortages in the primary health care workforce still continue to exist (Apodaca, 2007). The use of policy analysis and evaluation can provide additional realistic applications that can be embodied into strategies designed to reduce these disparities and improving health care delivery.

According to Creswell (2009), the sequential explanatory research design is useful when the need to substantiate quantitative data exists. As the literature reviewed substantiated the current and future shortage in the health care workforce in this country, any future research examining health care workforce should provide more than quantitative findings. Although this research method was more rigorous in its implementation, its benefits to explore this topic further are advantageous (Creswell, 2009).

The survey instrument utilized in this research was developed by The Physicians Foundation. The Survey of America's Physicians (SAP) conducted in 2012 is referred to as one of the largest and most comprehensive research instruments used to assess physicians' views on health care delivery (The Physicians Foundation, 2012). The authors of this study sought to understand the views of physicians on several issues impacting quality and access to care (The Physicians Foundation, 2012). In this study, almost 14,000 active physicians answered 48 multidimensional questions, many with multiple responses (The Physicians Foundation, 2012). The SAP instrument was formatted to collect online responses, and was configured to prevent duplicate responses

from the same computer. Appendix H contains the e-mail correspondence requesting and receiving permission to use, and republish, the SAP instrument in this study. While the SAP survey had its specific topics to be addressed, more than one-half of all physicians indicated that they intend to make changes to their practice that will likely reduce access to care and reduce the number of hours they see patients (The Physicians Foundation, 2012).

Expert Panel Review and Modification of Survey Instrument

After consulting with several health care experts, a modified SAP instrument and interview questions was forwarded to eight separate experts, who had signed confidentiality forms and who had extensive experience with health legislation and policy review. They were asked to confirm, make additions, and recommend deletions. Their recommendations were considered in a revision of the research instruments that was used in this study. The modified survey will also analyze the role health access legislation have on the practices of primary care providers. A sample of 20 health care providers was used in field testing this modified instrument.

The experts were also asked to review the survey prior to its use for content validity using the content validity index (CVI). The CVI is defined as "the degree to which an instrument has an appropriate sample of items for the construct being measured" (Polit & Beck, 2004, p. 423). A target number of 15-20 questions were anticipated in an effort to be concise and encourage completion of the survey. The surveys were returned to a designated post office box, where it was collected by the

researcher, and the returned envelope destroyed via shredding to further insure confidentiality.

Participants

Target Population

The goal of the quantitative section of this study was to have a sample size that would be reflective of the primary care provider workforce. The researcher utilized the online G*Power Data Analysis program to calculate the power analysis of this potential study. After completing the multiple sample size and power calculations for t-tests, regression analysis, and the effect size as a function of r^2, the researcher examined the mean, mode, and median obtained from these results for the best sample size. An average sample size of 650 participants was obtained from this power analysis.

Selection for participating in this study was based on the most current list of primary care providers provided by the online directory service Physiciandatabases.com and the professional medical group, American Medical Association. While there was a cost in using this database, these lists had a wide array of primary care providers across the United States. From these lists, a custom list of primary care providers could be created to select participants. This provides the opportunity to derive a smaller target list of primary care providers across the United States. As a sample size of 650 participants is required, initially 1,050 participants were recruited. The sample was selected using purposive sampling methods from the lists accessed from the American Medical Association and the Medical Professional database website, www.physiciansdatabase.com. The data was collected over a three month period.

According to Marshall (1996), in qualitative research, the sample size need not be representative of the population, but rather be able to establish an in-depth understanding of the population being researched. A sample for a qualitative study should not be too large, as it may become difficult to extract data, or too small where it may be difficult to achieve data saturation (Onwuegbuzie & Collins, 2007). A general rule recommended by the authors is a sample size of 10 - 12 participants in an interview. Following this rule, and possible time constraints the researcher used a sample size of 15 health care providers as the sample size in the qualitative aspect of the study.

Purposive sampling is one type of nonprobability sampling methods used by researchers to gather perspectives of a particular population (Trochim & Donnelly, 2006). The main goal of purposive sampling was to focus on particular characteristics of a population that are of interest, which will best enable you to answer research questions (Trochim & Donnelly, 2006). As the success of this study depended on the perspectives of participants, the participants in the qualitative study were limited only to health care providers who identified restrictions in their practice caused directly or indirectly by health access policies.

A letter of introduction was sent to participants describing the proposed research. This letter will serve as the Consent Form for Participants / Invitation to participate in the study and will request a response to indicate their willingness to further participate in the study. Appendix B is the Consent Form for Participants / Invitation to Participate in this research. Participants will also be provided with the Confidentiality Form (Appendix A).

These forms will describe the research purpose, reason for selecting the participants, and any possible risk associated with the research.

Demographic Data

Demographic data was collected and categorized in the analysis of both the quantitative and qualitative data. The decision to include demographic data is an important component of any research on health disparities (Derose, Gresenz, & Ringel, 2011). Presenting the demographic data not only provides a description of participants, but also allows comparisons within the population. The demographic data will be included, presented, and discussed further in Chapters 4 and 5.

Protection of Participants

Two consent forms were provided to participants. For respondents willing to participate in the qualitative data, one consent form should be returned with the survey, with the PCP providing his or her contact information and availability for a telephone interview. This consent form provided an explanation of the purpose of the research, the reasons for selection in this study, and the role of the participants in the research. The informed consent form also explained to the participant the opportunity to withdraw from the study at any time, without any professional repercussions or loss of services. With an effort to maintain participant's confidentiality and encourage honest and open communication, numbered identifications were used to identify each participant. All information, recordings, transcripts, and surveys will be kept in a lockable fire-proof safe. These will be kept for no more than 5 years, and then destroyed through a document security agency.

Participants will only be identified by their specialty practice. Therefore, no county, state, or place of employment were used to identify participants. For specific questions or issues that were not discussed thoroughly in the semistructured interviews, Walden University representative's contact information was provided to all participants who needed additional information or clarification. No research was undertaken prior to the Walden University Institutional Review Board's approval of the proposal for the study. Appendix B shows the Consent Form for Participants / Invitation to Participate, which contained Walden's IRB approval with approval number 11-24-14-0289591 that was distributed to all participants.

Data Collection

The data collection method that was used is the sequential explanatory design, as outlined in Figure 2. With the existence of over forty different types of mixed method research designs, the sequential explanatory design as discussed by Creswell and Plano-Clark (2007) is straightforward and provides researchers with the opportunity to build from quantitative data or instruments. According to the authors, the main feature of this research method is its ability to explain quantitative data results. Data collection began with the modified SAP survey instrument, shown in Appendix D. Following the analysis of this quantitative survey instrument, semistructured interviews were administered in order to identify common themes as well as the underlying reasons for the disparities in the supply of health care services. The survey was mailed to participants and each package included a self-stamped return envelope. Figure 2 highlights the steps that were used in the sequential explanatory data collection design.

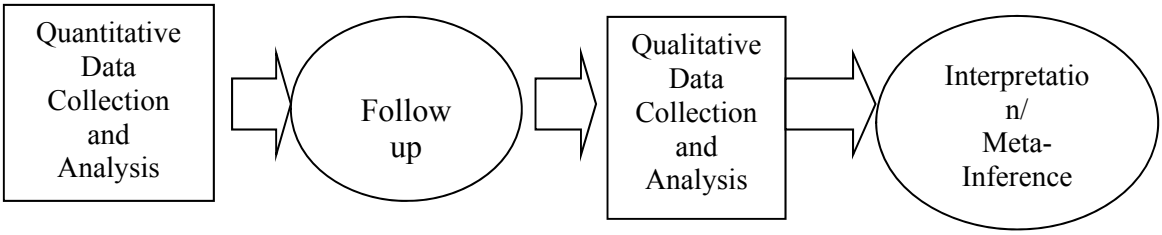

Figure 2. Sequential explanatory design data collection.

A total of 15 semistructured phone-interviews were conducted with health care providers across the United States to further explore this research topic. In order to remain consistent, all phone interviews were digitally recorded to allow the researcher to eliminate travel and time availability difficulties. The researcher's role was limited to the distribution of the original surveys, conducting the semistructured interviews, and the compilation of the data.

Analysis of the quantitative and qualitative data collected using the sequential explanatory design will occur independently (Greene, 2007). As the author discussed, this research design has two distinct yet interactive phases, starting with the collection and analysis of quantitative data, followed by a qualitative analysis (Greene, 2007). Bazely (2009) described this research design as a method to not only identify differences, but also provide an explanation of what these differences are. Referring to this as a connection, the author presented this method as one that can be used to discover the quantitative findings, followed an explanation of these findings (Bazeley, 2009).

Quantitative Data Collection and Instrument

One of the purposes of quantitative data collection was to make generalizations (Creswell & Plano-Clark, 2007). According to these authors, quantitative data collection

methods identify a sample representative of the larger population (Creswell & Plano-Clark, 2007). In this study, a survey was used to analyze whether or not there is a relationship between major health access legislation and the availability of primary care providers. The survey was designed to determine any impact health legislation may have on the practices of these health care providers.

The survey was mailed on November 25, 2014 to primary health care physicians using the active addresses listed in the physician database. The survey questions were concise and intended to encourage completion of the survey. A copy of the survey is attached as Appendix D. Composite scores were compiled for the survey questions and incorporated in the analysis along with written comments that may be obtained in conducting the survey.

Qualitative Data Collection and Instrument

Qualitative data collection began after completing the analysis of the quantitative data. Following the review of the quantitative data, interviews were arranged to clarify and identify the reasons health legislation restrict the supply of health care services. Using a semistructured interview format, interview questions were developed signed to solicit additional information from 15 participants. The Semi-Structured Interview Protocol shown in Appendix E was flexible, as interview questions may be reformed slightly based on the analysis of the quantitative data. A summary of these interviews was then done using codes that will identify the common themes identified in the responses. This summary allowed the researcher to compare results, in order to identify more

effective strategies that can be employed into the development and evaluation of health policy.

All the interviews were administered and conducted using the telephone. These were recorded and transcribed; and summaries created shortly after. Notes taken during the interviews were documented along with any other information such as follow up notes or further clarification that were needed in the data analysis. All these summaries and notes will also be included in the final analysis. Recordings and the related transcripts will be destroyed five years after the study's completion. The qualitative sample size were selected from the number of health care providers who indicated their willingness to participate in the interviews from the surveys by returning one copy of the Consent Form for Participants / Invitation to Participate.

The semistructured interview questions were based on the research purpose and research questions. Additionally, questions were developed using the recommendations provided by pre-existing literature used in the literature review. The questions were constructed using an open ended-format to encourage reflection and discussion on the experiences of the participants. Appendix E shows the Semi-Structured Interview Protocol used in the qualitative data collection. This semistructured format as discussed by Warner, Harrold, Allen, and Lyons (2010) is rigorous, but its flexibility allows a researcher to be able to capitalize on unexpected themes.

Qualitative Data Analysis

Creswell and Plano-Clark (2007) suggested that researchers utilize the most appropriate research instrument that can measure individual attitude and performance.

The sequential explanatory mixed method research design is used by researchers to identify potential differences with the intent to explain why these differences occur (Bazeley, 2009). In this study, the focus of the quantitative data was on the perceptions of PCP on the issues that contributed to the types and prevalence of the disparities. Phone interviews were conducted and the data analyzed be used to identify key themes, and explanations provided by the health care providers. Every participant was de-identified and only numerical codes were used as identification means. The records of this study will remain private, and original transcription records will be securely stored in a locked safe, accessible only by the researcher. Should this study be published in part or in its entirety, the researcher will not include information that can be used to identify any participant.

The primary reason for selecting this research design was to gather qualitative data that can clarify quantitative data. With this purpose in mind, analysis of the qualitative data were built off the results of the quantitative data. After the semistructured interviews are completed, all the interviews were converted to a text format, with the key ideas and phrases highlighted. The sample size was small for this section of the study, and the coding process was conducted primarily by hand. The software program CAQDAS was used and the themes obtained compared to those coded manually.

Integration of Data

Using a sequential explanatory mixed method research design allows one to combine both quantitative and qualitative data in order to obtain information not only of the prevalence of disparities in the primary health care supply, but also assess the specific

reasons for these disparities. The sequential explanatory research design collects quantitative data which is then analyzed to obtain an understanding of the research problem (Teddlie & Tashakkori, 2009). The subsequent collection and analysis of qualitative data can then be used to further explore and explain the participants' views, with the intent to provide a more complete analysis of the impact of health legislation on health care delivery. The use of multiple methods to collect data provides for verification and validity of the data collected (Denzin, 2012). According to the author, as more comprehensive data is collected, using triangulation methods from several sources such as a survey and semistructured interviews, inferences can then be made based on the analysis of the data (Denzin, 2012).

The purpose of this sequential explanatory mixed-methods study was to first assess if health legislation are contributing to the disparities in the supply of primary health care providers. Quantitative results were conducted using a survey, and then several individuals were randomly selected to further explore the meaning behind the quantitative data. This research design provides the benefit of capturing the trends or details of research problem that may not be adequately addressed by using solely a quantitative or a qualitative research design (Miles & Huberman, 1994).

According to Creswell (2009), in mixed method studies the emphasis should be placed on the timing of integration. While the method used will determine when the integration will take place, in this study the data was integrated at the point of interpretation. The collection and analysis of the data was conducted based on each research question.

Research Question 1: What is the relationship between health access legislation and the availability of primary care providers?

H_0: There is no relationship between health access legislation and the availability of primary care providers to deliver services.

H_1: There is a relationship between health access legislation and the availability of primary care providers to deliver services. The independent variable is health legislation and the dependent variable is the availability of health care providers.

Data to answer this question will primarily come from the survey instrument (Appendix D). The analysis was primarily obtained from the descriptive statistics obtained in the data. The data collection method for this question is the survey. The relationship of these two variables, the availability and willingness of health care providers and health legislation was analyzed using parametric and nonparametric statistical tests. This analysis will determine any statistical significance. Obtaining a *p-value* < .05, will indicate sufficient evidence to reject the null hypothesis. This was then cross-referenced with the results of the interviews to triangulate the data. Presentation of the results will be displayed in Chapter 4 using tables, figures, and charts.

As the surveys were administered by mail, the setting was not known. After the final wave of survey mailing, the data was manually entered into the data management and analysis software, SPSS and then analyzed. With regards to the interviews, these were administered by phone, and the notes and recordings were transcribed and analyzed.

According to Agretsi (2012), the characteristics of the quantitative data must be explored and presented, such as calculating the mean and standard deviation of variables

or groups. Once these are identified, further analysis should be done to compare these characteristics (Agresti, 2012). Using the steps for quantitative analysis described by Agretsi (2012), the data was analyzed and presented in Chapter 4. Statistical tests such as the Pearson's correlation test and the analysis of variance (ANOVA), along with descriptive statistics were done using Version 21 of the software program SPSS and conclusions made about the population. Pictorial representations such as bar graphs and tables were also provided in Chapter 4.

Research Question 2: What are primary care providers' perceptions regarding disparities in access?

Data to answer this question was obtained from the responses to survey questions eight and thirteen, and the results of the qualitative instrument, the semistructured interview (Appendix F). The analysis was primarily through identifying the major themes and codes.

In the qualitative analysis, the first step was to transcribe the data in its entirety. The transcriptions will then be read and reread for the purpose of coding, identifying themes, and making sense of the data collected. This was done without the use of software program. The analysis of the data section will include the major themes identified in the data transcriptions. Confidentiality was maintained with the transcriptions as well as the audio recording. Once the transcriptions were completed, copies were provided to all participants for their review and further commentary.

Quality

Despite the integration of both quantitative and qualitative data, as well as the increasing body of literature supporting the use of mixed method studies; concerns still exist about the study's rigor, reliability, and validity. Researcher bias, the lack of replicability, as well as being limited in making generalizations of the study's findings were few of the anticipated challenges ensuring that the research is of high quality. However, to ensure reliability, generalizability, and validity of the quantitative research; as well the credibility, dependability, and transferability of the qualitative research, quality efforts were implemented.

Reliability and validity of the survey were determined using intercoder reliability (Cook & Beckman, 2006). Using both the quantitative and qualitative data results, four categories were used to triangulate the data results. These were: PCP interest in influencing health policy, importance of PCP involvement in policy development and evaluation, satisfaction of the impact of health legislation on PCP practice, and restrictions legislation has on PCP practice. Triangulated data analysis was used to provide a more comprehensive account of a phenomena being observed or studied using two or more research methods. Methodical triangulation as explained by Thurmond (2001) is using more than one research method to understand the studied phenomenon very well Additionally, the use of multiple data collection methods were used to improve the credibility of the study.

Threats to Quality

The single most important threat to the quality of the study is the use of a modified survey instrument that has not been tested extensively. Additionally, any reduction in the anticipated sample size can also pose a threat to the quality of the study. The evidence of quality in a qualitative study is best described in terms of credibility, transferability, dependability, and confirmability, and how well the results of a study approximate the truth (Trochim & Donnelly, 2008). Because I also conducted qualitative research, I judged the quality of the results using the applicable concepts. Evidence exists that this study's results are confirmable and credible and, therefore, approximate the truth with regard to the perspectives of primary care providers' knowledge and interest, participation, satisfaction and restrictions of health legislation on their availability.

A target number of 15-20 questions were anticipated in an effort to be concise and encourage completion of the survey. The surveys were returned to a designated post office box, where it was collected by the researcher, and the returned envelope destroyed via shredding to further insure confidentiality.

To support the quantitative and qualitative steps in this mixed method approach, drafts of the survey and interview questions were forwarded to a group of eight health care experts with extensive experience with health legislation and policy review. The experts were asked to confirm, make additions, and recommend deletions. The experts' recommendations were considered in a revision of the final survey and interview questions. Another piece of evidence indicating both credibility and confirmability of my results is the interview participants' review of the qualitative data analysis.

Member checking was also performed. The results of the data and its analysis was provided to participants who were asked to review and make modifications to the abbreviated report. Member checking as posited by Trochim and Donnelly (2008) provides the opportunity to understand and assess what participants contributed, as well as provide the opportunity to correct errors and challenge the researcher's interpretations. Participants reviewed the preliminary data and provide additional comments and feedback.

Ethical Issues

While no ethical issues were anticipated, the potential for these to arise at any point in the process exist. I ensured that the study maintains a high ethical standard. Confidentiality and the protection of the survey instrument were important in minimizing potential issues. In complying with the educational requirements, written approval was requested and obtained from Walden University's Institutional Review Board prior to data collection. This study received approval from Walden University's Institutional Review Board on November 24, 2014, with approval number 11-24-14-0289591 and expiration date November 23, 2015. All identifying features were removed from the data collected to ensure the confidentiality of participants.

Limitations

The study limits itself by design to only practicing primary care physicians in the United States. No other health care provider were sought to participate in the study. As the researcher is also employed in the pharmaceutical industry, the potential for bias exists in the interview process. To reduce this possibility, the researcher will strictly

adhere to the pre-designed semistructured interview format. The researcher was available to provide clarifications for only the specific questions or comments instead of the intent of the interview process. Additionally, as the qualitative interviews with these health care providers were based on the results of the quantitative data, the potential existed for alternate comprehension and further interpretation of issue.

Summary

A sequential explanatory mixed method research design can provide an insight of the role health policy play in restricting the supply of health care services. By first utilizing a survey, specific policies and their effect on supply can be identified and comparisons made. This study sought to determine the role legislation plays in the delivery of primary health care, particularly how this restricts the availability of primary health care providers. Conducting semistructured interviews can help in determining the extent to which health care delivery is impacted by these legislation.

The purpose of this chapter was to explain the type of research conducted, the population and the sample, as well as to describe how participants' rights were protected during and after data collection. As described in the chapter, the sequential explanatory mixed method research design was conducted to examine the relationship between health legislation and the supply of services provided by health care providers. In Chapter 4 an examination of the results of the data collection will be provided, and Chapter 5 will provide a discussion of the conclusions drawn by the researcher as well as a summary of the dissertation.

Chapter 4: Results

Introduction

This study was conducted to examine the role major health policies in the United States play in restricting the availability of primary care physicians. Statistics show increasing disparities in access to U.S. health care services by individuals with and without health insurance coverage (Derose, Gresenz, & Ringel, 2011). This research study was conducted using both qualitative and quantitative data. The procedure used to collect data for this study was guided by mixed-methods sequential explanatory design.

This research study was designed to identify the relationship between health legislation and primary care providers' availability, and to obtain the perspectives of primary care providers on reducing disparities. Research Question 1 (RQ1) asked what relationship, if any, existed between major health access legislation and the availability of primary care providers. The modified Survey of America's Physicians (SAP) originally developed by the Physicians Foundation was utilized for this purpose. The researcher sought to evaluate:

H_0: There is no relationship between health access legislation and the availability of primary care providers to deliver services.

H_1: There is a relationship between health access legislation and the availability of primary care providers to deliver services.

Research Question 2 (RQ2) asked what are the perceptions of primary care providers' regarding reducing disparities in access? This research question was primarily answered using survey questions eight and 13, and the interview responses.

This chapter describes the data collection process including survey, interviews and participants for this mixed method study. In addition, data analysis and its relationship to both research questions will be presented.

Setting and Sample

I invited 1,050 U.S. primary care providers to participate in this study, using lists that I purchased from the American Medical Association and the Medical Professional database website at http://www.physiciansdatabase.com. The response rate was approximately 82%, with 861 completed survey responses that I used in this sample. Each survey mailing contained a Consent Form for Participants / Invitation to Participate, and a self-addressed stamped return envelope. The Consent Form for Participants / Invitation to Participate (Appendix B) provided a brief background of the study, its procedures, risks and benefits of participating in the study, and contact information for myself and a Walden University Institutional Review Board (IRB) representative. Semistructured interviews were later conducted with 15 randomly selected PCP who returned a Consent Form for Participants / Invitation to Participate form with their completed survey responses.

The researcher received 869 survey responses from the 1,050 mailings. Two of the returned surveys were not included as more than one page of the survey was incomplete. Six additional responses were not included in the data analysis because the responders stated they have not practiced within the past five years. The excluded data represent 0.92% of the total number of completed survey responses. Twenty-five participants who returned a signed consent form were randomly selected for interview.

Fifteen interviews were conducted and participants were labelled Participants P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P12, P13, P14, and P15.

Survey Process

This study was conducted after I first received approval from the Walden University Institutional Review Board, with approval number 11-24-14-0289591 and expiring on November 23, 2015. I obtained permission from the Physician Foundation to use the modified Survey of America's Physicians (SAP) survey as the survey instrument (Appendix D) was mailed to potential participants. Two Consent Form for Participants / Invitation to Participate was included in every mailing. Each potential participant was provided with the Consent Form, along with the survey and a self-addressed stamped envelope. After one month, a second mailing was sent out as a reminder to participants inviting them to participate. The survey was anonymous, and any identifying information such as addresses or name of practices included in the responses were shredded and not included in the presentation of data results.

Interview Process

With the informed consents obtained with the survey responses, I interviewed all 15 participants within a two-week period in January 2015. The semistructured interviews were digitally taped and lasted an average of 1 hour and 25 minutes. The longest interview was 1 hour and 58 minutes and the shortest interview was 55 minutes. All the interviews took place by phone. Interview questions began with discussions under each research question. Probes were used to gain a greater understanding of each participant‘s response. Occasionally, additional questions were asked when further clarification was

needed. All participants received a transcript of the interview within one week of completing the interview, giving them an opportunity to clarify details of the interview. Only two participants had corrections, all the other participants indicated that the contents of the transcript were accurate.

Data Organization and Analysis

I summarized the survey findings before comparing them with the interview findings. I used multiple ANOVA tests, Pearson' chi-square statistical tests, Kruskal-Wallis H test, and Spearman's rank correlation tests in SPSS to determine the weight of the participants' responses to the questions. Where possible, written comments from the survey were categorized and reported. The purpose of organization and analysis of the interview data was to review data and identify themes. Data related to each research question from the interviews along with demographic information were reviewed using constant comparative analysis and weighting the themes from the interviews. I also selected and examined interviewee comments that supported or illustrated the identified themes.

Demographic Findings

All participants in the survey and interviews were primary care providers currently practicing in the United States of America. From the purchased lists of providers, only those practicing for at least five years were selected. Tables 1 through 7 display demographic characteristics of the 861 primary care providers included in the sample. The gender of the respondents is summarized in Table 1. The majority of the

sample was male primary care providers at 63.5% (n = 547) while 36.5% (n = 314) were female respondents.

Table 1

Survey Participants by Gender

	Frequency (N = 861)	%
Female	314	36.5
Male	547	63.5
Total	861	100

The average age of the total sample was 49 years old (Table 2); and the most frequently recurring age of primary care providers was between 50-54 years with approximately 27% of respondents (n = 229).

Table 2

Survey Participants by Age

Age	Frequency (N = 861)	%
Less than 40	93	10.8
40-44	166	19.3
45-49	200	23.2
50-54	229	26.6
Greater than 55	173	20.1
Total	861	100

Table 3 presents the participants' breakdown by geographical location. Approximately 42% (n = 364) of respondents' practices were in urban locations, 30% (n = 261) were in suburban locations. Approximately 28% (n = 236) of respondents' practices were in rural areas.

Table 3

Survey Participants by Geographical Location of Practice

Location	Frequency (N = 861)	%
Rural	236	27.4
Urban	364	42.3
Suburban	261	30.3
Total	861	100

Table 4

Survey Participants by Region of Practice

Location	Frequency (N = 861)	%
Northeast States	93	10.8
Mid-Atlantic States	95	11.0
East North Central States	93	10.8
West North Central States	98	11.4
South Atlantic States	103	12.0
East South Central States	95	11.0
West South Central States	112	13.0
Mountain States	85	9.9
Pacific States	87	10.1
Total	861	100.0

Table 4 presents the participants' breakdown by the state regions. Nine state regions were used to categorize the participants. As shown in Table 4, Mountain States had the least number of participants, 85; while the West South Atlantic States had 112 respondents.

Table 5

Survey Participants by Employment Setting

Employment Setting	Frequency (N = 861)	%
Public	219	25.4
Private	213	24.7
Owner/Partner/ Associate	147	17.1
Educator	163	18.9
Other	119	13.8
Total	861	100

Table 5 presents the participants' breakdown by employment settings. One-fourth (n = 219) of respondents worked in public settings such as hospitals and clinics. Almost 25% (n = 213) of respondents worked in private health care facilities. A total of 119 identified their employment setting as other. Ninety-Five of these listed that they worked for Accountable Care Organizations (ACO).

Survey participants were asked if they were members of professional bodies. Approximately 59% (n = 508) stated that they were members of the American Medical Association, 38% (n = 327) stated they were members of the American Osteopathic Association. The remaining 3% did not answer the question or stated "Other" without providing the name of the group they are affiliated with.

Table 6

Survey Participants by Hours Worked per Week

Hours Worked per Week	Frequency (N = 861)	%
Less than 20	189	22.0
20 – 30	230	26.7
30 – 40	245	28.5
40 – 60	157	18.2
Over 60	40	4.6
Total	861	100

Table 6 shows the responses for survey question 19, on average, how many hours do you work per week. 664 PCP indicated that they worked less than 40 hours each week. Only 40 PCP stated that they worked greater than 60 hours each week.

Table 7

Survey Participants by Percent of Time Spent on Nonclinical Duties

% Time Spent on Nonclinical Duties	Frequency (N = 861)	%
None	61	7.1
Less than 25	213	24.7
25 – 50	316	36.7
Over 50	271	31.5
Total	861	100

Table 7 shows the responses obtained for survey question 20 asked, on average, what percent of your work time do you spend on nonclinical (paperwork) duties? Approximately 37% (n = 316) of PCP stated that they spend between 25% and 50% of their time each week on non-clinical duties. Another 32% (n = 271) spend greater than 50% of their time on non-clinical duties.

Statistical tests were selected using Agresti's (2013) steps for data analysis. Based on the type of variables, the number of variables, the expected fit to the parametric or

non-parametric assumptions, and the hypothesis being tested, the best statistical test was chosen. The researcher used the online G*Power Data Analysis program to calculate the power analysis of this potential study. As the power test required a minimum sample size of 650, no additional power tests were conducted as data was received from 861 participants. The normality and homoscedasticity of the data were measured to determine if a more appropriate test should be used. The results of each specific test will then be interpreted and presented. Results will be presented by research question.

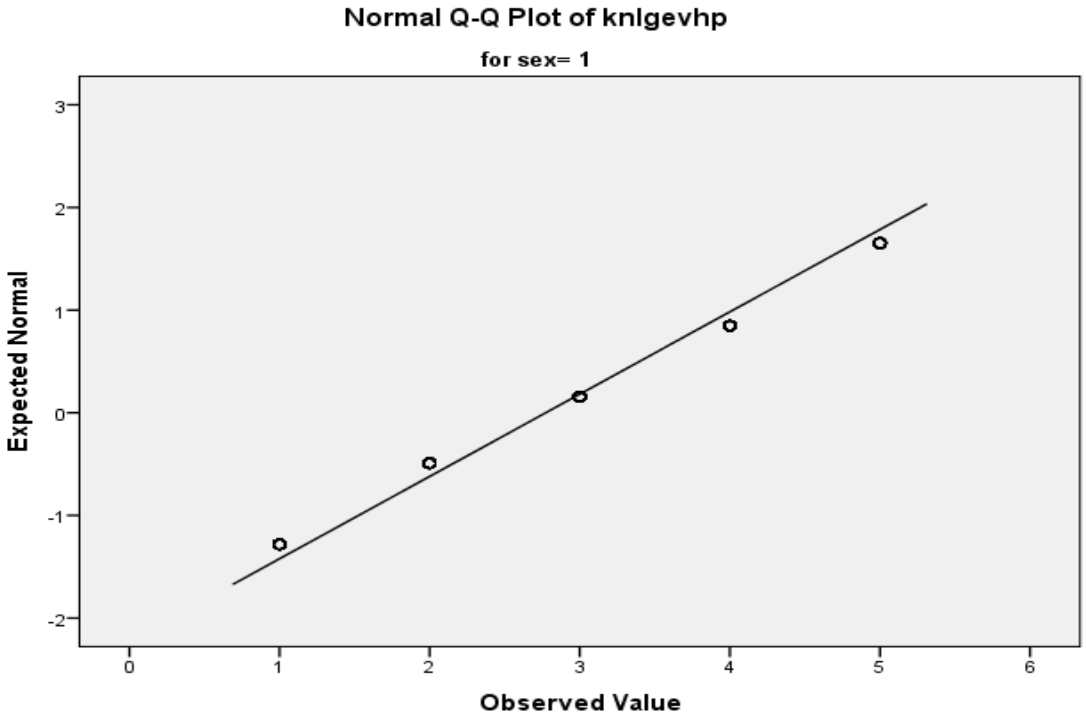

Figure 3. Diagram showing the Normal Q-Q Plot for variable knowledge for males

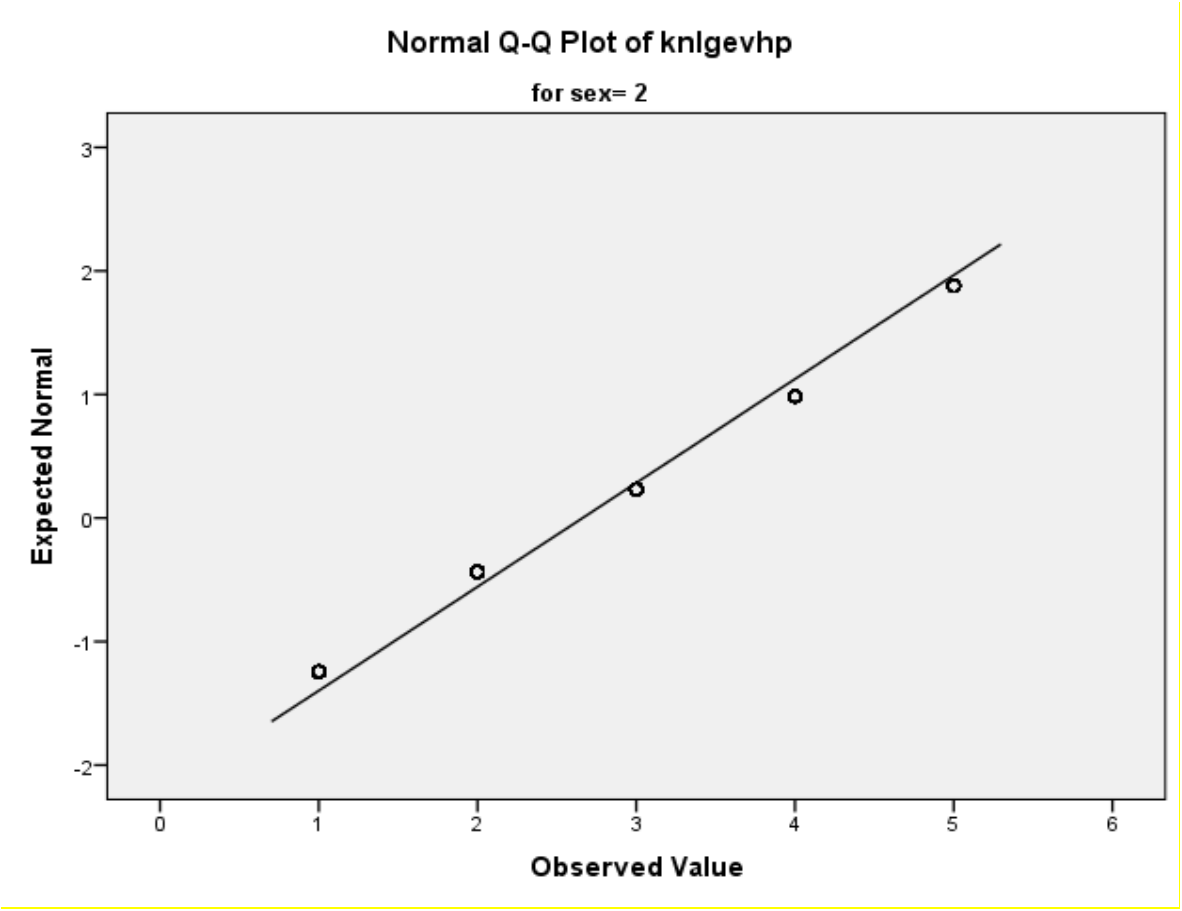

Figure 4. Diagram showing the Normal Q-Q Plot for variable knowledge for females.

Knowledge in evaluating health care policies and how they affect PCP practices were normally distributed for both males and females, as assessed by visual inspection of Normal Q-Q Plots (Figures 3 and 4). Additional Normal Q-Q Plots were performed for PCP interest in influencing policies as well as the satisfaction with the impact legislation has on PCP practices, and as assessed by visual inspection of Normal Q-Q Plots, the data were normally distributed for both males and females.

Results

The survey was mailed to 1,050 potential participants and the researcher's contact information was provided if further clarification was needed. No participant

called for clarification. Each survey mailing contained a self-addressed stamped envelope stamp envelope addressed to designated post office box to return each completed survey. After each survey response was opened, the return envelope was shredded. All responses from each of the 861 surveys were entered into the IBM SPSS Statistics 21 software program which was used to analyze the quantitative data. Participants were informed that all surveys were anonymous and the information would be kept confidential. Once the survey responses were entered into SPSS, the data codes and responses were checked twice to ensure that the information entered was accurate.

In Chapter 3, it was stated that multiple ANOVA tests would be used for the quantitative analysis based on the variables used in the survey. Pearson's chi-square tests were also performed on different variables in selected survey questions. According to Munro (2005), chi-square analysis should be used to test variables that are categorical, have frequency data, independent of each other, and have an adequate sample size. The questions related to the knowledge, interests, and satisfaction of health legislation were analyzed with the one-way ANOVA tests; once it was determined that the data fit all the underlying assumptions provided including normality and homoscedasticity. ANOVA tests were used for questions that used continuous variables, and response choices using several 5-point Likert scales.

A Levene's test was performed for each ANOVA test. The Levene's test operates in the same way as most inferential statistical tests (Agresti, 2012). In this case, it calculates a statistic which is compared to an F-distribution, with the p-value obtained indicating the evidence against the null hypothesis (Agresti, 2012). Therefore, a

statistically significant result indicates that we should accept the alternative hypothesis, which is that the population variances are not equal. As such, we usually hope to find that the test is not statistically significant and we have equal variances (Agresti, 2012).

Due to the types of questions being analyzed for the research questions, non-parametric tests including the Kruskal-Wallis H test and Spearman's rank correlation were also used in the analysis for Research Question 1 (RQ1). Correlation statistics were used to assess relationships from multiple variables, and were also used to describe the relationship between those variables. The Pearson's chi- square test was used to analyze selected questions from the survey to assess the impact legislation has on the satisfaction of PCP as well as the hours PCP work each week. Comparisons will be made between genders on the knowledge, satisfaction, and participation in the health care legislation process.

Survey questions using a Likert scale for responses were analyzed using Analysis of Variance tests. Munro (2005) stated that one way ANOVA tests should be used with one categorical independent variable that has two or more levels and one continuous dependent variable. A Scheffe's test was used in the ANOVA Post-Hoc analysis for multiple comparisons of the differences in means. For ANOVA results obtained with significance level less than 0.05, the Scheffe's test result will be highlighted. The Scheffe's test was chosen as it is considered to be one of the most flexible and conservative post-hoc test procedures to analyze the results of the one-way ANOVA tests when the decision is to reject the null hypothesis (Bergman, 2008). For those cases where the data fails the assumptions of the one-way ANOVA tests, a Kruskall–Wallis H test

was used once the data did not meet the normality assumption of the one-way ANOVA test (Bergman, 2008).

The Kruskal-Wallis H test is a non-parametric statistical analysis that provides information similar to that obtained utilizing one way analysis of variance (ANOVA) technique (Secomb & Smith, 2011). Like the ANOVA, the Kruskal-Wallis H test examines the equality of population means across three or more populations or groups. Unlike the ANOVA, the Kruskal-Wallis H test does not require a normal distribution nor does it presume equal variance among the distributions that are being compared. Because the intent of the study was to examine more than three independent groups, the Kruskal-Wallis H test was more appropriate than the Mann-Whitney U test that permits testing of only two samples (Bazeley, 2009).

These different tests were used in combination to answer all research questions. Multiple-choice questions were analyzed using a chi-square test, and in some cases, responses were summarized and presented using frequency data in the form of charts and tables. Likert-scale questions were analyzed using ANOVA. Independent variables used in this study were knowledge in evaluating health care legislation, race, and gender of survey participants, as well as PCP satisfaction of the impact of legislation on their practices. Dependent variable used was availability of PCP using the variable, number of hours worked by PCP. This study involved using testing the following null hypothesis:

1. There is no significant relationship between health access legislation and the availability of primary care providers to deliver services.

Research Question 1 was answered primarily with the survey questions. An alpha level of .05 was used for all ANOVA tests. Each survey question was analyzed separately. This section includes a description of the findings of the quantitative analysis. The findings are reported utilizing the research question of this study.

To answer Research Question 1, "What is the relationship between health access legislation and the availability of primary care providers" the survey questions were analyzed. The researcher analyzed the relationship between variables to identify factors that impact the number of hours PCP work each week.

The question "How knowledgeable are you in evaluating health policies that impact your practice" resulted in an F ratio of $F(4,856) = 4.144$, $p = .002$. The null hypothesis for this research question is that there is no difference in the mean knowledge of legislation of PCP who work fewer than 20 hours, 21-30, 31-40, 41-50, and greater than 50 hours each week. At the alpha level of .05, there is enough evidence to conclude there were differences in the mean knowledge in evaluating health policies between PCP who work different hours each week. However, there was not homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .019$).

A Kruskall-Wallis H test was then conducted to determine if there were differences in the mean knowledge of PCP who work the above mentioned hours each week. Distributions of hours were similar for all groups, as assessed by visual inspection of a boxplot. Calculation of the Kruskal-Wallis H test statistics resulted in $X^2_{K\text{-}W} = 13.473$, df = 4, $p = 0.009$. The $X^2_{K\text{-}W}$ value that was calculated as 13.473 and the p value of 0.009 indicated that there is a statistically significant difference in the mean knowledge of

legislation for PCP who work fewer than 20 hours, 21-30, 31-40, 41-50, and greater than 50 hours each week.

The analysis of the question "How interested are you in influencing health access policies" resulted in an F ratio of $F(4, 856) = 2.003$, $p = .092$. There was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .073$). At the alpha level of .05, there is enough evidence to conclude there were no differences in the mean interest in influencing health policies for PCP who work fewer than 20 hours, 20-30, 30-40, 40-50, and greater than 50 hours each week.

The analysis of the question "How important are primary care providers' input in developing health policies" resulted in an F ratio of $F(2, 858) = 3.426$, $p = .033$. At the alpha level of .05, there is enough evidence to conclude there is a relationship between physician availability and including PCP input in the development of health care policies. There was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .196$). The Scheffe's test results showed with $\alpha = 0.05$, we can conclude that the mean provider input is larger with PCP who work 30 – 40 hours each week than with those who work 40 – 50 hours each week. Also, the mean provider input is larger with PCP who work less than 20 hours each week than with PCP who work greater than 60 hours each week.

The analysis of the question "Please check any of the following that apply to your involvement in health policy in the past two years" was done using a one-way ANOVA test. A one-way ANOVA was conducted to determine if the PCP' involvement in changing health policy was different for PCP who were employed in public/government

entities, private entities, owner operated practices, or other types of employment settings. Participants were classified into 4 groups: public (1) (n= 192), private (2) (n= 235), owner or partner (3) (n= 199), and educator (4) (n= 235). There were no outliers, as assessed by boxplot; data was normally distributed for each group, and there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances ($p = .987$). The differences between these PCP practicing in different areas groups was not statistically different, $F(3, 857) = 2.108$, $p = .098$.

The question "Please check any of the following that apply to your involvement in health policy in the past two years" was further analyzed using another one-way ANOVA test. This resulted in an F ratio of $F(3, 857) = 2.775$, $p = .040$. At the alpha level of .05, there is enough evidence to conclude there was a relationship between physician availability and their involvement in changing health policy within the past two years. There was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .425$). The Scheffe's test results show that with $\alpha = 0.05$, we can conclude that the mean involvement in health policy in the past two years is larger with PCP working between 40 and 50 hours each week than with those working less than 20 hours per week.

The researcher analyzed whether there was a difference in male and female PCP knowledge in evaluating health policies that affect their practice. A two-way between-groups ANOVA test was used to analyze the question "How knowledgeable are you in evaluating health policies that affect your practice' was used. There was a statistically

significant difference in knowledge level scores for males and females, $F(1, 851) = 23.924$, $p < .005$, partial $\eta^2 = .17$

A Likert scale of 1 through 5 representing very dissatisfied (1) to very satisfied (5) was used to obtain responses for the survey question "How satisfied are you with the impact health legislation has on your practice (Circle one)". Table 8 illustrates the responses collected for this question.

Table 8

Responses to Survey Question 5, Satisfaction with the Impact of Legislation on PCP Practices

Rating	Frequency (N = 861)	%
1(Very Dissatisfied)	384	44.6
2	344	40.0
3	133	15.4
4	0	0
5 (Very Satisfied)	0	0
Total	861	100

A one-way ANOVA was conducted to analyze PCP satisfaction of the impact health legislation has on the practices of PCP was different for providers located in rural, urban, and sub-urban areas. Participants were classified into 3 groups: rural (n=384), urban (n=344), and sub-urban (n=133). There were no outliers, as assessed by boxplot; data was normally distributed for each group, and there was homogeneity of variances, as assessed by Levene's test of homogeneity of variances ($p = .146$). The differences between these PCP practicing in different areas groups was statistically different, $F(2, 858) = 10.608$, $p < .005$. The Scheffe's test results showed with $\alpha = 0.05$, we can conclude that the mean satisfaction is larger with PCP practicing in urban areas than with those who are located in sub-urban areas. Also, the mean provider input is larger with PCP who work in rural areas than compared to those working in urban areas.

Another one-way ANOVA test was conducted to analyze PCP satisfaction of the impact health legislation has on the practices of PCP was different for providers based on the hours worked each week. There was homogeneity of variances, as assessed by

Levene's test of homogeneity of variances ($p = .058$). The differences between these PCP practicing in different areas groups was statistically different, $F(4, 856) = 2.959$, $p = .019$. The Scheffe's test results showed with $\alpha = 0.05$, we can conclude that the mean satisfaction is larger with PCP who work more than 60 hours each week than with those work less than 20 hours each week. Also, the mean satisfaction is larger with PCP who work between 40 - 50 hours each week than with those work less than 20 - 30 each week.

The researcher also analyzed whether there was a difference in male and female PCP satisfaction on the impact of legislation on their practice. A two-way between-groups ANOVA test was used to analyze the question. There was a significant difference in satisfaction score for males and females, $F(1, 851) = 2.710$, $p < .005$, partial $\eta^2 = .220$.

Table 9 shows the questions analyzed using a one way ANOVA and an overview of the findings for Research Question 1 on the primary care providers views on the impact of health legislation on their practices of PCP based on the hours worked each week.

Table 9

Results of ANOVA Test for Mean Differences Among the Average Hours worked each week by Primary Care Providers Respondents Analysis

Question	ANOVA Results	Participants (Avg Hours worked per week)
How knowledgeable are you in evaluating health policies that impact your practice	p = .002*	0 - 20 (n = 189) 21 - 30 (n=230 30 - 40 (n=245) 40 - 60 (n=157) > 60 (n = 40)
How interested are you in influencing health access policies	p = .092	0 - 20 (n = 189) 21 - 30 (n=230 30 - 40 (n=245) 40 - 60 (n=157) > 60 (n = 40)
How important are primary care providers' input in developing health policies	p = .033*	0 - 20 (n = 189) 21 - 30 (n=230 30 - 40 (n=245) 40 - 60 (n=157) > 60 (n = 40)
How satisfied are you with the impact health legislation has on your practice	p = .019*	0 - 20 (n = 189) 21 - 30 (n=230 30 - 40 (n=245) 40 - 60 (n=157) > 60 (n = 40)
Please check any of the following that apply to your involvement in health policy in the past two years	p = .040*	0 - 20 (n = 189) 21 - 30 (n=230 30 - 40 (n=245) 40 - 60 (n=157) > 60 (n = 40)

To what extent do these restrictions affect the number of patients that you see daily	p = .584	0 - 20 (n = 189) 21 - 30 (n=230 30 - 40 (n=245) 40 - 60 (n=157) > 60 (n = 40)

Note. *indicates a significant relationship

Table 10 shows the responses for survey question 6, "Place a check next to what you believe restrict the scope of your services *the most".* Twenty-eight percent (n =241) of participants responded that uncertainty/changes in health care reform restricted the scope of the services they offered. Another 24% (n = 207) indicated non-clinical/administrative paperwork requirements restricted the scope of the services that they provide. Dealing with Medicare/Medicaid/Other government regulations was identified by 19% (n = 160) of respondents as restricting the scope of services. Reimbursement issues, lack of clinical autonomy, and managed care regulations were the other factors respondents identified that restricted the scope of their services.

Table 10. Factors that Restrict the Scope of Services Provided by PCP

	Frequency (N = 861)	Percent
Reimbursement issues	131	15.2
Lack of clinical autonomy	90	10.5
Medicare/Medicaid/Govt reg	160	18.6
Non-clinical duties	207	24.0
Uncertainties	241	28.0
Managed care regulations	32	3.7
Increasing training costs	0	0
Other	0	0
Total	861	100

One hundred and ninety two respondents stated that they were not involved in health policy development within the past two years. Approximately 27% (n = 235) respondents stated that they were involved through their professional bodies. Ninety-five percent (n = 223) of these respondents (n = 223) who were involved in changing health policy within the past two years through their professional organizations identified themselves as members of the American Medical Association. Two hundred participants were health policy advocates. Sixty-five percent (n = 130) of the American Osteopathic Association respondents considered themselves as health policy advocates and were involved in changing health policy in the past two years.

Figure 5 shows the frequencies of the responses to Survey question number 9, "What do you think are barriers in developing more effective health policies". Lack of time and uncertain outcome, were identified as the leading barriers in developing health policies. Other notable barriers were frustration with the policymaking process, political influences, lack of money or resources, and the possibility that the policy will not make a difference in health care delivery.

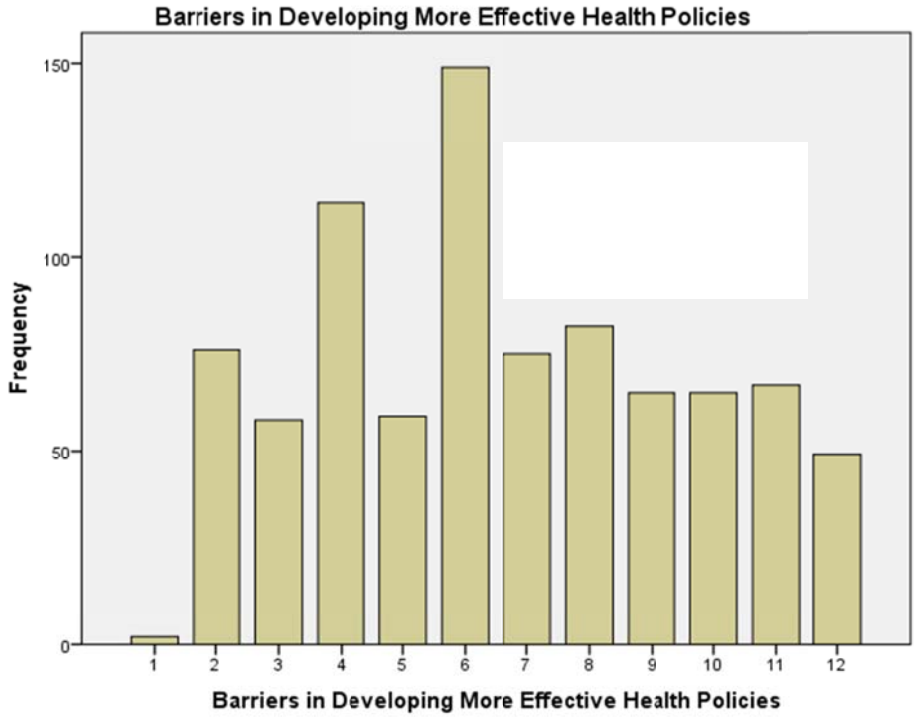

Figure 5. Barriers in Developing More Effective Health Policies

Similarly, Figure 6 shows the leading benefits participants list for the question "What do you think are benefits of health policy development and evaluation". Having HCPs comply with laws was identified by 18% (n = 157) of respondents as the greatest benefit of policy development and evaluation. Reducing disparities with 13% (n = 111) and improving health care quality with 12% (n = 104) were the other leading benefits PCP identified. Other responses included, creating uniform standard of care, and making a difference in patients' lives.

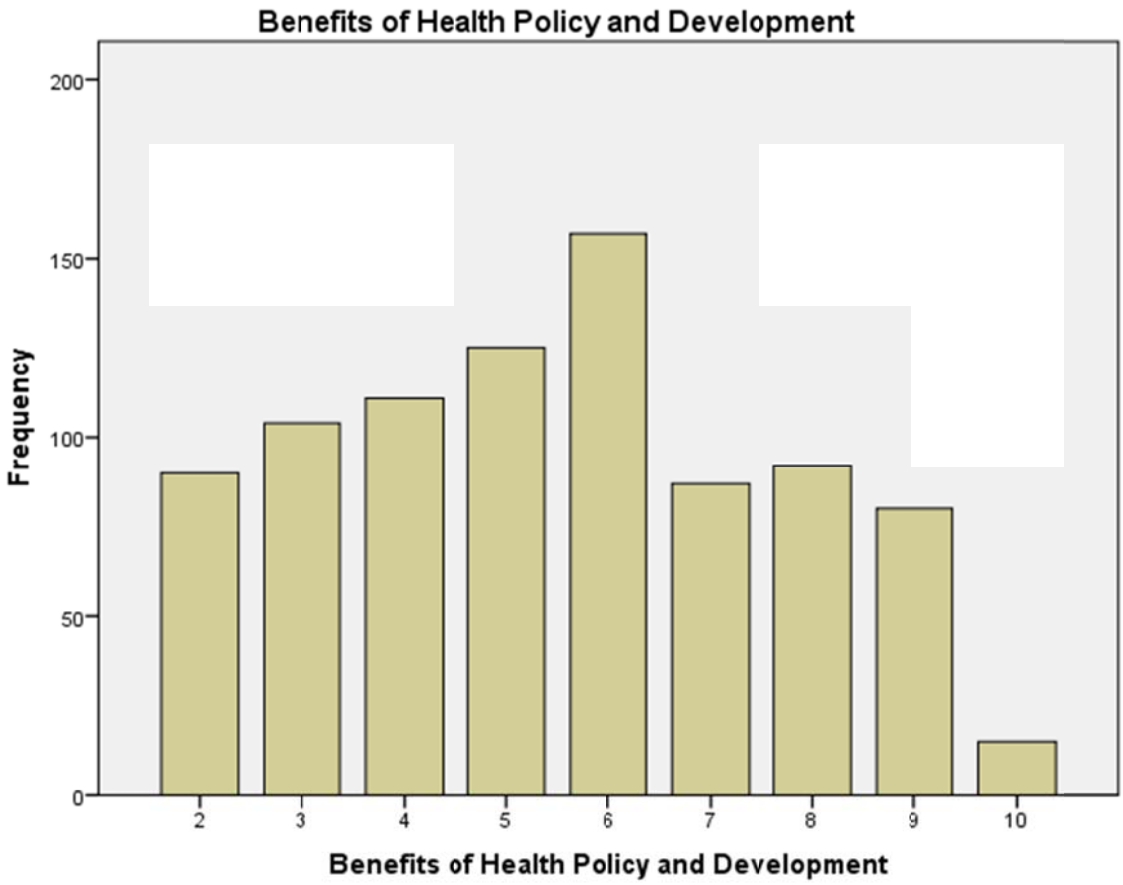

Figure 6. Factors that PCP identify as benefits of health policy development and evaluation.

Survey Question number 11 "Which of the following contributes to your dissatisfaction as a PCP" had all 861 respondent identify one dissatisfaction. Twenty-nine percent (n = 255) were dissatisfied with the low reimbursement rates for their services. Administrative hassles / non-clinical paperwork were identified as the second highest factor contributing to their disaffection. Fee-for service reimbursement requirements, and decreasing autonomy were the other leading factors. Ten respondents selected other for

their choices. Among the list of factors listed as "Other" were financial debt, practice startup costs, and the high provider to patient ratio.

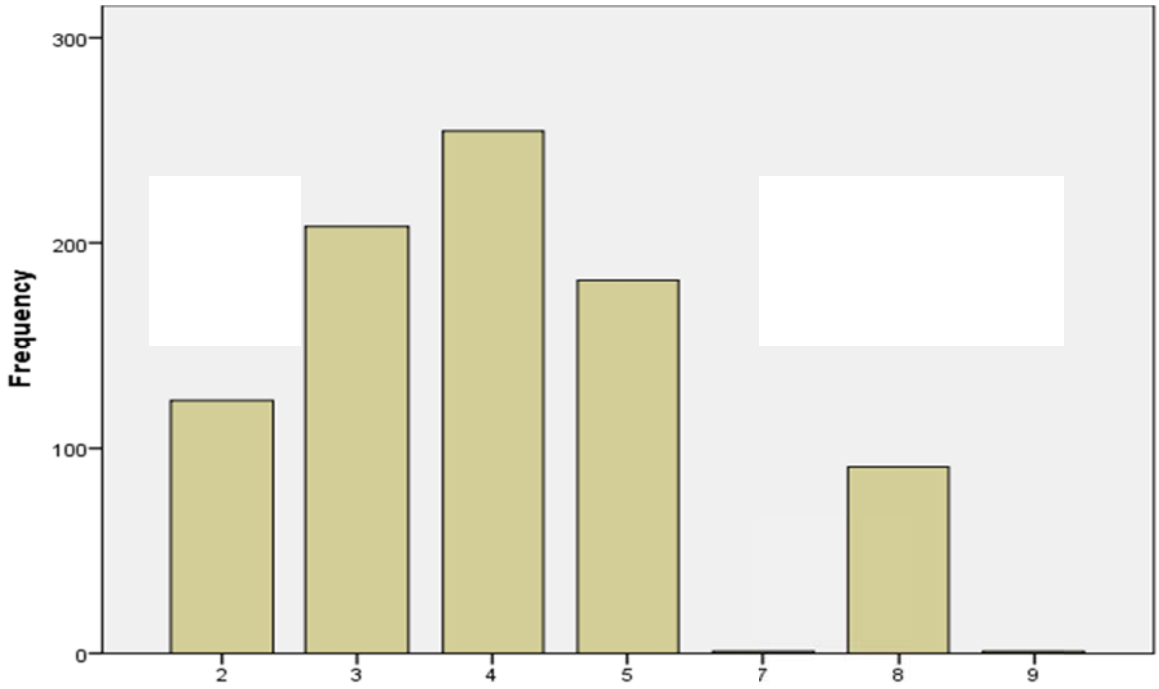

Figure 7. Factors that contribute to PCP dissatisfaction.

Forty-two percent (n = 371) of respondents stated that they received information or training on how to implement and analyze the effect the Patient Protection and Affordable Care Act (PPACA) will have on their practices. More than half (n = 498) of the respondents stated that they did not receive adequate training or information on how to implement and analyze this new legislation and the impact it will impact their practices. Thirty-five percent (n = 127) of respondents received this information or training for workshops, 29% (n = 105) received information for professional

organizations that they belonged to, while 28% (n = 101) received in-the-job training on how this new legislation will impact their practices.

A Pearson correlation was run to assess the correlation between satisfaction of the impact of health legislation and employment setting, and satisfaction of the impact of health legislation and the geographical location of practices. Preliminary analyses showed the relationship to be linear with both variables normally distributed, as assessed by Shapiro-Wilk test ($p > .05$), and there were no outliers. Using the guidelines provided by Agretsi (2012) where the absolute value $0.1 < |r| < 0.3$, there was a small positive correlation between satisfaction and employment setting**,** $r(859) = .106$, $p = .002$. There was a negative correlation between satisfaction and geographical location, $r(859) = -.019$, $p > .05$. Since the p-value is greater than .05, then we cannot conclude that the correlation between satisfaction and geographical location of practices is different from 0. Another Spearman's rank-order correlation test was done to assess the correlation between satisfaction and the extent to which these affect the number of patients PCP see each week. While there was a negative correlation coefficient between satisfaction and the extent to which this affects the number of patients seen, the p-value again was greater than .05.

A Spearman's rank-order correlation was run to assess the relationship between satisfaction of the impact of legislation on PCP practices and age of PCP. Preliminary analysis showed the relationship to be monotonic, as assessed by visual inspection of a scatterplot. There was a negative correlation between age and satisfaction, $\mathbf{r_s} = -.101$, $p < .0005$.

A chi-square test for association was conducted between gender and PCP hours worked each week in order to assess if there was a relationship between PCP genders and hours worked each week. All expected cell frequencies were greater than five. There was a statistically significant association between gender and average hours worked each week, $\chi^2(16, N=861) = 34.813$, $p = .004$.

Another chi-square test for association was conducted on satisfaction and geographical location of practices. All expected cell frequencies were greater than five. There was a statistically significant association between satisfaction and rural, urban, and suburban practice locations, $\chi^2(4, N = 861) = 22.712$, $p < .005$.

A chi-square test for association was conducted between PCP hours worked each week and satisfaction on the impact in evaluating health policies. All expected cell frequencies were greater than five. There was a statistically significant association between and preference for performing competitive sport, $\chi^2(8, N = 861) = 18.392$, $p = .018$. There was a statistically significant association between gender and average hours worked each week, $\chi^2(4, N = 861) = 34.813$, $p = .004$.

Qualitative Data Analysis

The concepts and ideas of the study's respondents must be formulated to show collective experience. Researchers can learn the lived experiences of participants when they carefully listen to the responses each participant provides (Creswell & Plano-Clark, 2007). The general information from the responses will then be tied together to obtain an in-depth understanding of the perceptions of PCP (Creswell, 2013). This provides the advantage of examining individual experiences by providing a description of what the

shared experiences of the participants are (Creswell, 2013). By reviewing the transcripts of the interview sessions, qualitative data analysis will highlight significant statements (Creswell, 2013). Themes were derived from these significant statements which will allow the research to be described through a composite description (Creswell, 2013).

The themes were derived using primarily manual coding. As a secondary check, the qualitative software Computer Assisted Qualitative Data Analysis (CAQDAS). These themes generated from CAQDAS will then be matched against the themes derived from the manual coding process to triangulate the qualitative data with the quantitative data.

Telephone interviews sessions were conducted by the researcher with PCP who returned the Consent Form for Participants / Invitation to Participate (Appendix B). These interviews were digitally recorded. Participants were informed that while their answers were not anonymous, they would be kept confidential. The researcher informed all participants that all information shared in the interview session would stay in the session and information shared would not be tied directly to each participant. Following the interview, participants were told that they will be provided with a written transcript of the interview, and encouraged to review and provide any clarifications or additional information to provide an accurate reflection of their statements. All transcriptions from the interview sessions have been kept in a secured location.

Each interview was digitally recorded, transcribed, and analyzed from the original transcriptions. This method was used to provide credibility of the data analysis. Each transcription was reviewed by the participants for significant statements related to

knowledge of health access legislation, perception of these legislation, and the experiences these legislation have on their practices.

The following research questions were used to analyze these qualitative data:

1. What are primary care providers' perceptions regarding reducing disparities in access?

Survey question 13 was also used to answer this research question along with the responses from the interview sessions.

Semi-structured telephone interviews were conducted for the qualitative data of this research study. Once the qualitative data collection was completed, three levels of coding were used; descriptive coding, topic coding, and analytical coding (Creswell, 2009). The first phase of analysis utilized descriptive coding to review each interview based on the hours worked by each physician and gender. Themes were identified after coding responses into categories utilizing topic coding. Finally, analytical coding was used to place topics into themes. Axial coding was also used to answer each research question so a response could be identified for a theme. Themes were used for more than one research question. Inductive reasoning was used to create subgroups of responses and then develop themes. Each theme was derived from similar responses across each category of participants. Responses were qualified to contribute to a theme.

In order to support the development of a theme, only subcategories with two or more coded responses were used. Coded responses were then organized to show how one code supports another by placing the coded responses into subcategories (Schutt, 2012).

Responses which were coded into subcategories could be used to support more than one theme. The use of subcategories overlapping in more than one theme also shows how the concepts of subcategories support each other (Schutt, 2012). Identified themes were also used to answer both research questions in this research study.

Research Question 1(RQ1) "What is the relationship between health access legislation and the availability of primary care providers" was answered using the analysis of all 15 semistructured interviews. The five themes that emerged from this analysis were: PCP focus more on daily requirements rather than on understanding health policy; controlling cost, quality or access affect physicians; PCP have little influencing in affecting policy; lack of interest in increasing supply of PCP; and decreasing PCP remuneration.

Descriptive Analysis

Table 11 shows an overview of these themes which are supported by direct quotes in the thematic analysis overview. The table displays the number of responses from the semistructured interview participants. The following themes were identified in all PCP based on the hours each participant stated that they worked each week. The table displays the number of coded responses supporting each theme. There were a total of 15 participants in the interviews; 4 PCP worked less than 20 hours each week, 3 PCP worked over 20 hours but less than 30 hours each week, 3 PCP work between 30 and 40 hours each week, 3 PCP worked between 40 and 60 hours each week, and 2 PCP work more than 60 hours each week.

Table 11

*Interview Responses and Themes of the Relationship Between Health Legislation and Primary Care Provider Availability (Hours Worked Each Week) (*N = *15)*

Themes	<20	21 – 30	30 – 40	40 – 60	> 60	Theme Total
PCP focus more on daily requirements rather than on understanding health policy	4	2	3	0	2	11
Controlling cost, quality or access affect physicians	3	3	3	3	1	13
PCP have little influencing in affecting policy	3	2	1	2	0	8
Lack of interest in increasing supply of PCP	4	3	2	0	2	11
Decreasing PCP remuneration	3	3	3	2	2	13

Thematic Analysis

The first theme for Research Question 1, PCP focus more on daily requirements rather than on understanding health policies emerged based on discussion on physician work schedule. Key elements that were used to identify this theme were responses surrounding time spent on delivering health care services to patients. Each participant relayed personal experiences on the time spent seeing patients. Eleven PCP mentioned that PCP focus more on their daily duties rather than understanding how to evaluate the impact policies have on how they provide care. When asked to define what these daily duties were; the participants stated overseeing staff, maintaining practice requirements, participating in health conferences and pharmaceutical seminars, reviewing new studies

or clinical trial information, educators at universities and medical schools, and with time permitting they will oversee the patients referred to them by their support staff. These PCP stated that they were either partners or owners in health care practices. Four of these 11 providers stated that they hire several physician assistants (PA) and nurse practitioners (NP) to deliver primary care services and focus more on the daily duties identified above. The four PCP who did not mention this theme stated that they were employees of health care facilities.

Through the discussion on expanding the number of actively practicing PCP, the topic of the PPACA emerged. The theme surrounding improving access, quality and reducing costs was mentioned by 13 participants. One interesting statement repeated by multiple participants was the direct relationship improved access, quality and cost reduction has on the number of hours health care providers work. While the PCP agreed that they were willing to work more hours, they would prefer less emphasis be placed on cost reduction and improved quality. One PCP stated “If the PPACA wants us to see more patients, then we should be able to solely set our rates. You can’t expect us to want to see more patients when you only reimburse a portion of the true costs, or have insurance plans that limit how often patients can seek care, or penalize us when patients do not completely recover”. When asked to expand further, the PCP stated that many of the patients seen in the practice who obtained through the insurance market place provide free preventive care services annually. The amounts reimbursed to his practice, are significantly less than what they received in previous years. In some cases they were up to seventy five percent less than the amounts received in the past 5 years.

Another PCP stated that reducing health care cost is one of the "major reason I focus more on not seeing patients". The respondent reason further stated "While I love the health care profession, I would like to operate a financially successful practice". The PCP further stated that "this is basic accounting. Reducing the cost that you can charge patients will result in lower business income. To add to that, the cost of treatment and medical equipment are expensive. To be reimbursed less than what the cost of treatment is worth, will send myself and many of my colleagues into bankruptcy". Similar statements were also mentioned by 12 other respondents. Another respondent stated that in order to improve access, more physicians have to increase the limits on their insurance coverage, as this will increase the malpractice lawsuits, thereby increasing costs in the long run.

Policies implemented to reduce health care costs, and or improve access to care are viewed as health care reform to many of the participants. As Participant P10 stated, "all policies will lead to a change in physician behavior. For example, the PPACA has great intentions. However, moving from a fee-for service system, will directly and indirectly lead to restrictions in access to health care provider. This will only lead to an upheaval in the way many physicians practice".

The theme PCP have little influence in affecting health care policy was identified by 8 of the participants. Participant P2 stated that "Primary care physicians are really the core of healthcare delivery. However, we have little ability to affect changes to the system or its overall direction. Sometimes I feel powerless, but yet I still have to operate. Sometimes I think we are powerless. I have been a primary care physician for almost 30

years, and I have never been more discouraged in our ability and willingness to participate in the development or evaluation of health policies". Similar statements were echoed by three other respondents. Some shared the view that the younger aged physicians need to become more involved in policy development and continued evaluation to save the primary care health delivery system.

The theme of lack of interest in increasing the supply of PCP emerged through the analysis of the question on how to correct PCP perceptions on the restrictions they face. As stated by Participant P11, "sometimes it is difficult to know if it is the legislation that restricts the supply of PCP. Before I became a doctor, there was a shortage of primary care providers. Over the years, this has continued to decline while more new physicians are more interested in specialized care. Those providers also have the same legislation, but more people find specialized care more attractive". Participant P6 also added that" it is important for policymakers to know that PCP are in short supply and greater demand whether as a result of legislation, market forces, or any other reason will directly or indirectly impact the current supply of PCP". Another respondent stated that "everyone knows that there are not enough PCP. However, no effort has been successful in improving the number of primary care physicians". Interestingly, all PCP who work less than 40 hours each week mentioned this point. None of participants who worked between forty and 60 hours per week mentioned this theme.

One of the themes identified by 13 of the 15 participants was the decreasing remuneration PCP receive. Participant P6 stated that "the incomes of PCP have always been lower than those of specialty care providers". 8 participants mentioned the declining

income they have seen over the past 5 years. Participant P12 stated “this has little to do with federal or state policies in my opinion. Even reimbursement from private health insurers have been declining. As we speak, I am looking at some of the charges that I have seen declined. I can no longer be reimbursed for many of the procedures I perform, and when I am reimbursed, they are at a lower rate compared to those I received years ago”.

Research question number 2, “what are the perceptions of primary care providers’ regarding reducing disparities in access” was answered by all 15 interviewees as well as survey questions eight and 13. Table 12 shows the frequency of the responses for survey question 8. Table 13 shows the frequency of the responses for survey question 13.

Table 12

Responses for Survey Question 8

	Frequency					
	No Impact				**Great Impact**	Total
Ongoing Medicare fee changes	24	190	165	263	219	861
Implementation of Electronic Medical Records.	260	253	176	172	0	861
State and federal insurance mandates.	221	266	109	126	139	861
Federal government intervention.	43	15	229	385	189	861
Centers for Medicare and Medicaid Services sustainable growth rate estimates and calculations.	259	274	328	0	0	861
Charity care requirements.	488	173	168	14	18	861
Medicaid's high member-to-PCP ratio	335	172	19	168	167	861

Note. Survey question 8, Please Indicate the Impact each of the following has on your Practice

Table 13

Responses for Survey Question 13

	Frequency					
	Not Likely				**Extremely Likely**	Total
Medicare voucher system	22	119	270	270	180	861
More government regulation	378	292	179	2	10	861
Less government regulation	8	0	159	378	316	861
Increasing the number of primary care physicians educational facilities	23	4	22	538	274	861
Increasing the remuneration of primary care physicians	17	5	0	150	689	861
Revising the reimbursements requirements without significantly decreasing PCP reimbursement rates	33	0	84	280	464	861
Expanded knowledge base and resources for internal improvement	11	30	1	339	480	861
Developing a health care system that places greater emphasis and value and benefits of primary care services	0	0	113	358	390	861
More effective and flexible charity care mandates	44	0	234	402	181	861

Note. Survey question 13, Please rate how likely the following would remove the restrictions on PCP practices and reduce disparities in access.

Descriptive Analysis

The six themes that emerged from this analysis were: pessimism in the future of the US health care system, PCP will continue to work less hours each week, increasing emphasis on chronic care will attract less PCP, improving health care access and quality

will remain a challenge for policymakers, mistrust of insurance companies, and health care access can only be improved if PCP are directly involved in policy development and evaluation.

Table 14 provides an overview of these themes which are supported by direct quotes in the thematic analysis overview. The table displays the number of responses from the semistructured interview participants. The following themes were identified in all PCP based on the hours each participant stated that they worked each week. The table displays the number of coded responses supporting each theme. Again, there were a total of 15 participants in the interviews; four PCP worked less than 20 hours each week, three PCP worked over 20 hours but less than 30 hours each week, three PCP work between 30 and 40 hours each week, three PCP worked between 40 and 60 hours each week, and two PCP work more than 60 hours each week.

Table 14

*Interview Responses and Themes of the Relationship Between Health Legislation and Primary Care Provider Availability (*N = *15)*

Themes	<20	21 – 30	30 – 40	40 – 60	> 60	Theme Total
Pessimism in the future of the US health care system	2	3	2	1	2	8
PCP will continue to work fewer hours each week	4	2	3	2	2	9
Increasing emphasis on chronic care will attract less PCP	4	2	2	1	0	5
Improving health care access and quality will remain a challenge for policymakers	4	3	2	2	2	9
Mistrust of insurance companies	2	2	2	1	2	7
Health care access can only be improved if PCP are directly involved in policy development and evaluation	4	3	2	3	2	10

Thematic Analysis

The theme of pessimism in the future of the health care system in the United States emerged through analysis of the questions, what are your thoughts on the Healthy Program Initiative to reduce disparities in access to health care services; and what advice would you provide to health care stakeholders currently focused on reducing disparities

in access? Participants in all five groups expressed pessimism in the future of the US health care system. Participant P1 stated that "over the past 10 years, this is the least optimistic I have been in the future of health care delivery in the US". Participant P4 stated "while I am in favor of the PPACA, it does no not do enough to attract more PCP. Maybe other health care providers will be trained to be PCP, but with an increasing population, it will be difficult to deliver adequate care with the current PCP workforce". Four of the respondents stated that the Healthy People Initiative has great goals. However, "expanding the supply of PCP has been a goal for many years and in my opinion will be a goal for at least the next century" said Participant P3.

"While not a perfect system, our quality of care ranks very high compared to other developed countries" was the statement made by one respondent. Participant P5 further stated that, "more than eight of ten patients that I see have insurance coverage. Yet many people with insurance do not get adequate care. By adequate I mean do not get regular checkups, or utilize health services appropriately. Maybe legislation has something to do with this, but I think it has more to with patients not utilizing health care services until it's too late". Participant P6 echoed similar comments and added that "it is no secret that PCP are few in numbers. However, until greater emphasis is placed on the value and importance of primary care services, then the US will be filled with sick persons". Only one PCP working between 40 and 60 hours each week identified this theme.

Participant P8 who works between 40 and 60 hours each week stated that "the medical profession is in a decline. I spend most of my time on non-clinical duties and

spend fewer and fewer hours each week with my patients. I am sometimes frustrated when I spend less time seeing my patients". Participant P8 who works over 60 hours each week mentioned in his comments that "I work for a living and I cannot afford to continue seeing declining income in my practice".

The theme PCP will continue to work fewer hours each week was one of the themes that emerged from 13 participants. All 13 participants stated that they work fewer hours last year compared to previous years. Participant P1 stated that "working fewer hours translates to seeing fewer patients". Five of these respondents stated that they plan to cut back on hours worked and have even considered leaving primary care practice. Participant P15 stated "if we continue to see decreasing reimbursement rates by private and government insurers, we will not have any other choice but to leave primary care and become educators, or serve in other capacities". The profession has become less financially rewarding and sometimes it is the least encouraging thing to see patients not value their health as they should". One of the participants in the group, "PCP working greater than 60 hours per week", stated that "I will continue to be a PCP for as long as I am able to. It is what I was born to do. So until I can no longer do it, I will continue to encourage patients to utilize primary care services".

The theme increasing emphasis on chronic care will attract less PCP emerged from the responses of 9 participants. Participant P10 stated "health care costs are high because of chronic diseases". Participant P1 stated that "patients are becoming sicker and sicker each year. Health promotion is not important. Instead, it is all about treating illnesses. Often times through discussions with my patients, I realize that more only

believe in seeing the doctor when they are ill. If we are here, and patients are not utilizing our services, then this is the reason chronic illnesses are on the increase". The other 7 PCP mentioned the need to promote preventing illnesses to reduce the increases in chronic illnesses. None of the two PCP who work more than sixty hours each week spoke about the increasing emphasis on chronic care.

Thirteen participants mentioned the challenges policy makers will continue to face in developing more effective health policies. The theme improving health care access and quality remaining a challenge for policy makers was mentioned multiple times. Participant P8 mentioned that "many policymakers are not PCP and I believe that this is one of the biggest problems with the policy making process. Policymakers need to spend more time with PCP before making decisions. I think this is a major mistake. They want to improve access, but have no idea what causes patients to not see PCP". Participant P13 stated "policymakers get paid to make best judgments. Unfortunately these best judgments are anything but". This Participant P6 further added that "sometimes I wish they would be realistic and make policies that can actually work".

The theme mistrust of insurance companies emerged from the responses on reimbursement and payments rates. Both participants A and H mentioned the increasing profits insurers make compared to the decreasing income of PCP. Participant P14 shared an experience with an insurer's decreasing reimbursement payments, as well as the time it takes to receive reimbursements. As a result, this participant will not see patients who have this type of insurance. Participant P11 stated "unfortunately patients are unable to pay directly for much of the health services they are provided. So we must rely on third-

party insurers. While they are necessary to the medical profession, this compromises the level of care patients received. Many of us have learnt the hard way that insurers are often our worst enemies. We prescribe a treatment for our patients, and when they go to the pharmacy, they receive other treatment options". No participant differentiated between government and private insurers in their responses.

All but one participant stated that health care access will only be improved if PCP become directly involved in the policy development and evaluation process. Participant P12 indicated that as long as things continue the way they have been for the past twenty years, primary care delivery within the US health care system will continue to decline. One of the statements on reducing disparity made by Participant P12 was "we have a broken system filled with many band-aids. If things continue the way they are today, we may not have many new PCP entering the field. Once I retire, I plan to become more involved in the policy making process. I am not sure how far I will be able to go but with my experience as a PCP, I will try my best to indirectly improve the lives of consumers and the satisfaction of PCP". Responses also included "there are policies that look good in theory, but are detrimental to many PCP practices", "sometimes policymakers really do not know what works", and "policymakers are failing health care providers and health care consumers". Additionally, PCP stated that after years of medical training it is discouraging to face many of these challenges that can have been prevented.

Triangulated Data Analysis

Triangulated data analysis is used to provide a more comprehensive account of a phenomena being observed or studied using two or more research methods. Methodical

triangulation as explained by Thurmond (2001) is using more than one research method to understand the studied phenomenon very well. One of the benefits of methodical triangulation is "increasing confidence in research data, creating innovative ways of understanding a phenomenon, revealing unique findings, challenging or integrating theories, and providing a clearer understanding of the problem" (Thurmond, 2001, p. 254). The mixed method research design was selected to provide a picture of the perceptions of the impact of health legislation on the practices of primary care providers. According to Patton (1990), this dual approach will not present a clear-cut picture, but can improve comprehension of the reasons for any inconsistencies between the qualitative and quantitative data sets. These qualitative and quantitative data analysis results for this study were also placed into previously identified categories mentioned in Chapter 3 of interest in influencing health policy, importance of PCP involvement in policy development and evaluation, satisfaction of the impact of health legislation on PCP practices, and restrictions legislation has on providers' practices. These categories are being used to identify the overall perception of the impact health legislation on the practices and scope of services offered by primary care providers.

Methodological triangulation was done to illustrate the predominant themes between the qualitative and quantitative data collected. The coding and triangulation of these qualitative and quantitative data in this study was done as a means to paint a picture of the perceptions primary care providers share on any impact health access legislation has on the delivery of services, as well as their views on improving access and reducing disparities.

The coding of these qualitative and quantitative data also show how the results from each of these analyses overlap with each other and support the findings of both sets of data. Through the combination of qualitative and quantitative data in this section, an over-arching view of knowledge, beliefs and perceptions in each of the categories is provided. Table 15 provides a brief synopsis of the findings already discussed for each theme.

Table 15

Triangulated Themes

Triangulated Theme	Qualitative	Quantitative
Interest in influencing health policy	PCP focus more on daily requirements rather than on understanding health policy	There is not a significant relationship in the perception of PCP survey respondents that are interested in influencing health policies.
Importance of PCP involvement in health policy development and evaluation	Health care access can only be improved if PCP are directly involved in policy development and evaluation.	There is a significant relationship in the perception of PCP survey respondents that believe that PCP should be involved in policy development and evaluation.
Satisfaction of the impact of health legislation on PCP practice	Pessimism in the future of the US health care system	There was a positive correlation between satisfaction and the number of hours worked each week.
		84.6 percent of PCP respondents were either very dissatisfied or dissatisfied with the impact of health legislation on their practices
Restrictions legislation has on PCP practice	PCP will continue to work less hours each week	71 percent of survey respondents identified uncertainty/changes in health care reform, non-clinical requirements, and Medicare/Medicaid regulations as the major restrictions

These categories are being used to identify the overall perceptions of primary care providers.

Evidence of Quality

As stated in Chapter 3, this mixed methods research study used a sequential explanatory design. This design follows a pattern of collecting and analyzing quantitative data first, followed by collecting and analyzing qualitative data (Tashakkori & Teddlie, 2003).To support the quantitative and qualitative steps in this mixed method approach, drafts of the survey and interview questions were forwarded to a group of eight health care experts with extensive experience with health legislation and policy review. The experts were asked to confirm, make additions, and recommend deletions. The experts' recommendations were considered in a revision of the final survey and interview questions.

The participants in the interviews were also involved in improving the quality of the data. Within a week of the interviews with primary care providers, transcripts of their interviews were sent to the interviewees for any necessary clarifications and approval. There were only 2 additions. One PCP suggested that I added that the pessimism in the future of the health care system only relates to physician reimbursement rates and improved access. Another PCP stated that the mistrust of insurance companies relates only to how they reimburse primary care providers. No PCP made suggestions with regard to my interpretations of the data; however, they urged that the results be made available to other health care policymakers.

In this study, interpretation of the data obtained from the survey responses were used to as probing questions in the interview process. The semistructured interviews used

constant comparative analysis and the use of numbers to give weight to the interview responses. Leech and Onwuegbuzie (2007) cited one of the most frequently used approach in interpreting qualitative data is the use of constant comparative analysis. The use of constant comparative analysis supports identification of underlying themes; using the identification of chunks of information and the subsequent assignment of worded codes to each chunk. Maxwell (2005) stated that many qualitative researchers give weight to themes by using the words, *for example*, *some, usually,* and *most*, and that the use of numbers to assign weights to themes can be valuable and legitimate.

Another example of credibility in my study is the result of the triangulation of data. The data collected from participants used two different data-collection instruments. In addition to the above measures, responses to the interview questions were compared to similar responses on the survey to test for quality of the data and the results. Care was taken to adequately describe the methodology of this research so that future replication would be possible.

Summary

The purpose this study was to examine the role major health policies play in restricting the availability of primary care providers. Chapter 4 described the data collected during the study. Standard procedures of a sequential explanatory mixed method design were used to conduct the analysis of this study. Research question one consisted of quantitative and qualitative procedures and was addressed in that order. The methods used for quantitative analysis were descriptive statistics, one-way ANOVA, and

Pearson's chi-square correlation tests, using SPSS to determine relationships within the items of the instrument.

In conducting this study, themes were identified from the analysis of the perceptions of PCP of the impact legislation has on their practices and to assess their views on reducing disparities in access. Analysis of the survey data revealed there was a significant relationship in the knowledge in evaluating health policies among PCP who work fewer than 20 hours, between 20 and 30 hours, 30 and 40 hours, 40 – 60 hours, and greater than 60 hours each week. The results of the analysis also found that even though there was a significant relationship in the satisfaction of the impact of health legislation on PCP practices among PCP who work fewer than 20 hours, between 21 and 30 hours, 30 and 40 hours, 40 – 60 hours, and greater than 60 hours each week, there was not normality in the data. The results of the quantitative analysis found that there was also a significant relationship in the PCP involvement in the past two years among PCP who work fewer than 20 hours, between 20 and 30 hours, 30 and 40 hours, 40 – 60 hours, and greater than 60 hours each week.

The qualitative analysis for research question 1 (RQ1) revealed that there were several themes that emerged that included PCP focus more on daily requirements; controlling costs, quality, or access affect physicians; PCP have little influence in affecting policy; lack of interest in increasing PCP supply; and decreasing PCP remuneration. Several themes also emerged from the qualitative analysis for research question 2 (RQ2). These were pessimism in the future of the US health care system, fewer hours being worked by PCP, increasing emphasis on chronic care will attract less PCP, improving access and quality will remain a challenge for policymakers, mistrust of

insurance companies, and health care access can only be improved with more PCP becoming involved in policy development and evaluation.

The triangulated data analysis revealed how the findings fit into specific categories related to interest in influencing health policy, importance of PCP involvement in health policy development and evaluation, satisfaction of the impact of health legislation on PCP practice, and restrictions legislation has on PCP practices. There were similarities in these qualitative and quantitative data in the areas of all four categories. This analysis provided overarching themes for comparison of these qualitative and quantitative data. Chapter 5 will offer an interpretation of the analysis of these data and a summary of the findings of the study. The summary will include a discussion of how the data was triangulated to corroborate quantitative data with the qualitative data. Chapter 5 will begin with an introduction followed by interpretation of findings, implications for social change, recommendations for action, recommendations for further study, and an overall summary of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this sequential mixed-methods study was to examine the role that major health policies play in restricting the availability of primary care providers (PCPs) in the United States. Data were collected from 1,050 surveys were mailed and 869 surveys were returned. Eight of these were not included as pages were either incomplete or respondents indicated that they have not been actively practicing. Fifteen participants were interviewed from the twenty-five participants who returned a signed consent form Interviewees were labelled P1 through P15. The data results from these quantitative and qualitative phases were then used in a triangulated data analysis to examine four areas related to PCP interest in health policy, importance of involvement in health policy development and evaluation, satisfaction with the impact of legislation, and the restrictions identified as a result of legislation. The triangulated data analysis provided an overarching view of combined qualitative and quantitative themes.

This chapter presents the findings of this research study and answers to the primary research questions and compares the data collected to the literature search findings in Chapter 2. Chapter 5 also includes the recommendations for actions recommendations for further research, implications for social change, and a chapter summary.

Interpretation of Findings

Interpretation of the findings will be done by each research question.

Research Question 1 (RQ1): What is the relationship between major health access legislation and the availability of primary care providers?

H_0: There is no relationship between health access legislation and the availability of primary care providers to deliver services.

H_1: There is a relationship between health access legislation and the availability of primary care providers to deliver services.

Eight survey responses received were not included in the analysis due to incomplete responses, and respondents indicating that they have not practiced within the past five years. To answer research question one (RQ1), I entered the data from 861 survey responses into SPSS. The primary purpose for collecting quantitative data was twofold; to analyze whether there is a relationship between health access legislation and the availability of primary care providers, as well as to triangulate the survey responses with the data collected later in interviews. Based on the findings in Table 15 and other quantitative analysis in Chapter 4, there were significant relationships between participants understanding health legislation, satisfaction with the impact of health legislation on their practices, and their perceptions of including PCP in policy development; and the hours worked each week.

Previous research has shown that there is a shortage of primary care physicians and other primary care providers (Collins & O'Brien, 2011). The Patient Protection and Affordable Care Act (PPACA), Healthy People 2020 Initiative, and other national programs seek to increase the supply of primary care providers. According to Hagland (2014), the PPACA will not increase the number of practicing primary care providers. In an attempt to address the current shortage, in late 2014, the Primary Care Physician Reentry Act was introduced in Congress. Though this act was never passed in

Congress, it sought to improve the nation's primary care physician shortage by providing training and financial assistance to doctors returning to medical practice in exchange for their service as a public health provider (Hagland, 2014).

Physicians' attitudes and behaviors related to their satisfaction have often ignored the role the impact of legislation has on their satisfaction as well as how it contributes to restricting their services. This study sought to explore the role legislation has on PCP dissatisfaction and availability. Themes identified in this study were knowledge and interest in influencing health policy, participation in health policy development and evaluation, satisfaction with the impact legislation has on PCP practices, and restrictions faced in delivering health services. Interpretations of the findings have been provided according to each of these themes.

Knowledge and Interest

The description of knowledge and interest used for this study was the importance, awareness, or attention health care providers place in the specific decisions and events undertaken by policymakers to achieve a desired health outcome (Cherry & Trotter Betts, 2005). Survey questions number 4 and 5 sought to examine participants' knowledge and interest in the policy development and evaluation process. The analysis indicated that there was a statistically significant relationship in participants' knowledge in evaluating policy; however, there was not a statistically significant relationship in participants' interest in influencing health policies.

An explanation for these findings was provided using step 1 of Patton and Sawicki's policy analysis model: identifying the problem. One concern Participants

P3, P4, P5, P6, P7, P9, P10, P11, P12, P13 all mentioned was a view that most primary care providers do not understand related legislation, and instead focus on their daily activities rather than on understanding health policy. Additionally, the frequency data for survey question two showed that only 226 participants were either interested or very interested in influencing policy development. As stated in Chapter 2, the role existing health policies have on the daily practices and the supply of health care providers remain underassessed and misunderstood (Runy, 2009).

As Buchan (2010) stated, the lack of the stability and consistency in the practices of health care providers contributes to a broken health care system. Buchan further suggested that any attempts at real reform should begin with an examination of health care policies enacted within the past three centuries and their effect on health care provider practice in the United States. Feldstein et. al. (2013) stated that the PPACA is confusing and this could be contributing to the lack of PCPs comprehension and interest in health policy development and evaluation. PCPs can provide important perspectives that could help optimize policy evaluation to improve future health outcomes (Feldstein, et al., 2013).

One of the conclusions made in the Physician Foundation's 2012 survey report was PCPs have trouble fully understanding what policymakers are trying to achieve (Physician Foundation, 2012). This finding was validated by the results of my own interview analysis. A recurring theme that emerged from the interview analysis was that PCP focused more on daily requirements or responsibilities rather than on understanding policies. Participants P1, P2, P3, P4, P5, P7, P8, P10, and P13 all commented on the lack of PCP

interest in affecting policies. This finding was consistent with previous studies on PCP involvement in policy development (Mittman & Sullivan, 2011). According to Buchan (2010), the US health care delivery system is complex, but has at its core the relationship between health care provider and patient. Enhancing PCP satisfaction and interest in developing policies should be an important goal not only to attract more PCPs, but also to improve the health care delivery system.

Participation

PCPs participating in policy development is a critical consideration in any health care policy development strategies (MacDonald, 1992). The ANOVA results presented in Table 9 that were conducted on the survey questions linked to participating in policy development and evaluation, resulted in a *p* value less than the 0.05 significance level. Similarly, recurring themes of the interview analysis suggested that PCPs believed that health care access can only be improved when PCPs are directly involved in policy developments.

Step 2 of Patton and Sawicki's policy analysis model focuses on determining policy objectives. The objectives listed in the PPACA and the Healthy People 2020 Initiative include a focus on increasing the number of primary care providers. According to Pardes (2009), few proposals have led to the development of legislation that will effectively address any possible restrictions health care providers face as a result of new health care policy requirements. As discussed in Chapter 2, Abood (2007) cited the increased participation of health care providers in policy analysis and development. Despite this, the findings presented in Chapter 4 indicate a high percentage of PCP with

inadequate information and training on the PPACA. The theme of uncertainties in health reform also supports the findings of Jacobson and Jazowski (2011) discussed in Chapter 2. If providers are not fully accepting of this new legislation, then these providers can quickly become marginalized in the legislative process (Jacobson & Jazowski, 2011). Respondents however, agreed that there are several benefits to policy development and evaluation. Clearly highlighting the objective of each policy clearly may have an increased effect on PCP participation.

The third step of Patton and Sawicki's policy analysis model is establishing an evaluation criteria. Providers stated that they spend less time on understanding the policy development and evaluation process. Another theme emerging from the qualitative data analysis is the uncertainties in health reform. As Jacobson and Jazowski (2011) detailed, if PCPs' fear of the uncertainties continue to grow, more has to be done to evaluate the policy development. LeClair (2011) stated that the criterion must be precise and clearly communicated between parties, including PCP delivering care. The interpretation of these findings suggests that PCP participation and involvement in the policy development and evaluation process can be more beneficial.

Satisfaction

Satisfaction was described as the extent to which a person's hopes, desires, and expectations about the employment he or she is engaged in are fulfilled (Fortney, Luchterhand, Zakletskaia, Zgierska, & Rakel, 2013). Four survey questions assessed PCP satisfaction: 3, 9, 18, and 20. The ANOVA results showed p values < 0 .05 significant levels. Fortney et al. (2013) stated that the low work satisfaction of primary care

physicians is a growing concern and this can have a negative influence on health care policy development. Derose, Gresenz, and Ringel (2011), stated that in order to reduce disparities in health care, it is important to first understand the inequities that contribute to the dissatisfaction of health care professionals.

Step 4 of the policy analysis model focuses on identifying alternatives. Thirty percent of the number of respondents stated that low reimbursement rates contributed to their dissatisfaction as a PCP. Other notable factors included non-clinical duties, fee-for-service requirements, and decreasing autonomy. Survey question 13 sought to examine how likely several factors may remove restrictions on PCP practices. Six hundred and eighty nine respondents identified increasing remuneration rates as extremely likely to remove restrictions. Revisions to the remuneration levels PCP receive, as well as expansion to the knowledge base for internal improvements were the other likely factors PCP identify that can remove these restrictions.

As a means of triangulating the data, the interview analysis was used to validate this finding. During dialogue with interview participants, 8 participants mentioned their pessimism in the future of the US health care system. Nine participants believed that PCP will continue to work fewer hours each week. As the quantitative data analysis shows there is a positive correlation between satisfaction and the number of hours worked each week, focus should be placed on developing alternatives aimed at improving PCP satisfaction. This finding is congruent with previously conducted studies that have reported positive correlations between the

satisfaction of primary care providers, patient satisfaction, and improved care (Jacobson & Jazowski, 2011).

Restrictions

Jacobson and Jazowski (2011) discussed restrictions as the resulting consequences of the inability to ensure access to quality, and culturally competent care. Data analysis related to restrictions resulted in no significant results from the quantitative statistical test results. No items from the one way ANOVA (Table 9) produce results that indicated that restrictions affected the number of patients seen daily. However, Table 7 show that non-clinical duties, uncertainties in health reform, and Medicare / Medicaid / Government regulations were reported as the leading issues that restricted the scope of services offered.

The themes that emerged from the qualitative data analysis relating to restrictions were pessimism in the future of the US health care system, and the continued decrease in PCP working hours each week. These themes were also consistent with the findings of the Survey of America's Physicians conducted in 2012 and the concerns of the future of America's primary health care which discussed how providers are frustrated to the point of openly criticizing payers (Hagland, 2014).

Research Question 2 (RQ2): What are primary care providers' perceptions regarding reducing disparities in access?

Survey question 13 asked respondents to rate how likely nine factors may be able to remove restrictions PCP face in their practices and reduce disparities in access. Using a Likert Scale of 1 – 5 (Not Likely to Extremely Likely), a total of 839 respondents

selected numbers 4 and 5 as their response to increased remuneration of primary care providers. Using the same Likert Scale, 819 respondents selected the option "expanded knowledge base and resources for internal improvements" as more likely or extremely likely to reducing health disparities. Zero respondents selected options 1 or 2 on the same Likert scale for option " Developing a health care system that places greater emphasis and value and benefits of primary care services" for this question.

During the interview PCP were asked to describe their perceptions on improving access and reducing disparities. Nine participants (P1, P2, P3, P4, P6, P9, P10, P12, and P14) believed that health care access will continue to be a major challenge for health care policy makers. The theme health care access can only be improved if PCP are directly more involved in policy development and evaluation, were identified in the data collected from ten of the interview participants.

Steps five and six of Patton and Sawicki's policy analysis model are focused on assessing the possible alternatives, and implementing and evaluating new policies. These alternatives must be comprehensive and their advantages and disadvantages explored. In the Health People 2010 Final Review – Complete Report published in 2013, Object 01-05, persons with a usual primary care provider did not meet its target of 85 percent (Centers for Disease Control and Prevention, 2013). In fact, between the assessed period 1998 – 2008, the rate met was between 76 and 78 percent (Centers for Disease Control and Prevention, 2013). In creating the Healthy People 2020 Initiative, new objectives were added including ones related to the primary care workforce (Centers for Disease Control and Prevention, 2013).

While this study did not assess all legislation, or explore in depth alternative procedures to the policy evaluation process, both the quantitative and qualitative data analysis demonstrated the need to begin assessing current or alternative solutions to reducing disparities. Participant P9 mentioned that primary care providers are ignored or silenced in health care policy decision making. Participant P9 commented further that PCP are not able to advocate for themselves or the profession. In examining the responses to survey questions eight and thirteen, policy makers are able to review the issues that may have "no impact" or "great impact" on reducing the restrictions PCP face, as well as those issues that are "not likely" or "extremely likely" to reduce disparities and improve access to primary care services.

One of the topics discussed by all interview participants is health reform. Some respondents discussed creating greater emphasis on primary care, increasing the supply of primary care physicians, reassessing remuneration processes, as well as increased PCP participation in policy development. Many agree that these will be in some type of reform, however, there are differences in perspectives in how to achieve these results. One respondent suggested having less government intervention in physician remuneration discussion, while another suggested less could lead to further inequities in physician income levels. The findings of this study display why primary care providers are not available to provide care based on their perceptions of existing health legislation.

Limitations of the Study

There were several limitations to this study. Primary care providers in this study are physicians designated as those practicing family medicine, general internal

medicine, or pediatrics. Data was not distinguished by primary care specialty to provide practice-specific analysis. Availability was measured as the number of hours primary care providers spend each week seeing patient and were divided into five groups. The sample size for each group was not evenly distributed. Future research should make an effort to have data collected from groups with sample sizes evenly distributed. Also the demographic data collected for these qualitative and quantitative portions were collected from a mix of male and female participants and groups were not evenly distributed. This did not allow for these data to be analyzed deeper looking at the differences in this population. Data used for these qualitative and quantitative portions of this study were only collected from primary care providers who are currently practicing. This prevented these data from being generalized to other types of health care providers. Additionally, qualitative data collected utilized only15 participants.

Recommendations for Action

In light of these findings I suggest four recommendations for action. The first recommendation is for health care policymakers relating to increasing the number of primary care providers. The Agency for Healthcare Research and Quality (2015) estimates that in 2010, there were 208,208 practicing primary care physicians in the United States 2015. According to the 2010 American Medical Association Physician Masterfile approximately 30% of new physicians are entering primary care practice (United States Department of Health and Human Services, 2013). Policymakers should review how policies are preventing expanding the primary care workforce.

The findings of this study indicate that the primary care providers are pessimistic in their views on the health care system. Many respondents mentioned the lack of interest in increasing the supply of practicing primary care physicians. Policymakers also need to re-examine the effectiveness of existing policy and increase the participation of PCP in policy development and evaluations. For example, by expanding educational and training programs, PCP can become more interested in policy development and evaluation, or be more prepared to lessen some of the restrictions and dissatisfaction they currently experience.

One of the Healthy People 2020 objectives is to increase the number of practicing primary care providers (U.S. Department of Health & Human Services, 2013b). The findings of this study can be incorporated into designing specific methods to meet this objective. Respondents stated that primary care providers should be involved in health care policy development and evaluation. While this study did not provide detailed analysis by practice region or state, its findings can be used by not only the Healthy People Initiative, but also by local partners in their efforts to attract new health care providers to their communities. By understanding the availability of providers in each community, local health stakeholders can not only develop community-specific policies, but also will be able to attract more providers to their communities. How primary care providers feel about policy development and evaluation has an impact on the effectiveness of these objectives and other policies.

Both opponents and proponents of the PPACA agree that more effective strategies or legislation are needed to improve access and utilization of health

services. While this legislation aims to expand access to health services, concerns exist about how this will affect the health care workforce. With the focus on preventive care, the current shortage in the number of primary care providers suggests that the workforce may be inadequate to meet the current and future health needs of the population. While it is true that this and other health policies have been implemented to expand the health care workforce, disparities in access will remain prevalent until the restrictions PCP identify that limit the availability of health care providers are identified and addressed. Any attempt to address disparities in access should examine the supply and availability of the health care workforce through policy analysis and evaluation.

Policies must be continually assessed. To health care educators, I would recommend revising medical school curricula as well as physician continued education and training programs. Previous studies have shown that physician dissatisfaction may have an adverse effect on health care outcomes, quality, and cost (Sommers, Swartz, & Epstein, 2011). By improving health education programs, physician satisfaction may be enhanced as providers' tolerance for uncertainty in daily care may be enriched as their knowledge of and increased participation in policy evaluation are expanded. The findings in this study show that physicians do not understand many health policies, and are not optimistic about the future of the health care delivery system. Participants agree that primary care providers should become more involved in health policy development. One finding show that providers learnt of the PPACA through magazines or other media sources.

Recommendations for Future Research

This doctoral study focused on the knowledge and perceptions of primary care providers evaluating the role of legislation on PCP availability and reducing health disparities. Future studies on this topic should explore both knowledge and perceptions to gain a deeper knowledge of not only primary care physicians, but other health care providers. This study used a modified version of a survey instrument developed and tested in 2012. Future research on this topic should enhance these quantitative instruments to assess the impact of new legislation such as the PPACA on primary care providers' availability. More qualitative studies should be conducted to continue improving health care delivery.

Findings specific to the satisfaction of the impact of health legislation on provider practices can be used to guide future research. The finding of approximately 85% of respondent responding that they were either dissatisfied or very dissatisfied with the impact of health legislation on their practices should be further analyzed and recommendations provided to health care policymakers.

More sequential mixed method studies utilizing qualitative data to probe deeper on survey data would be useful to gain additional information surrounding improving access to care in local communities. The study can be replicated using different research questions such as (a) How does the PPACA affect the scope of services PCP provide?, (b) Is there is significant difference between PCP satisfaction before the PPACA, and after the PPACA?, (c) What are health care providers' perceptions on improving the remuneration rates and process? Another recommendation is to conduct a comparative

study of primary care providers' perceptions with specialty care providers' perceptions of the effectiveness of provider input in health care policy development and evaluation.

Implications for Social Change

Positive social change is "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies" (Walden University, 2013, p. 5). The PPACA has been implemented with much critique. One of the provisions of this health legislation is the $230 million funding allocated to increasing the number of primary care providers (United States Department of Health and Human Services, 2011). Many health care stakeholders estimate that this will attract approximately two thousand more primary care physicians by 2015. While expanding the PCP workforce is welcomed by many respondents in this study, more needs to be done to expand primary care physicians' availability. In order to improve health care access and reduce disparities, health care stakeholders must re-evaluate how existing policies impact health care delivery. There are several implications for social changes in this study.

One implication is designing more effective policy evaluation and development methods or processes. One of the findings identified in this study is the low satisfaction on the impact of health policies on PCP practices. As shown in the findings in Chapter 4, no respondent stated that they were satisfied or very satisfied with the impact of health legislation on his or her practice. Subsequently, many state their lack of optimism in the future of health care delivery. While fair and equitable policies should be implemented, it is clear that the impact of these policies is either underevaluated or misunderstood by

policymakers. The findings in this study can be incorporated into enhanced policy evaluation and development practices and procedures, which can increase the number of new PCP entering active practice as well as the retaining physicians in the workforce.

The data findings indicate that not all primary care providers understand existing legislation. Another implication for social change this study provides is the potential to influence PCP education and training. Not only can programs be developed to improve the knowledge of primary care providers of the intended impact of health polices, other health care providers, administrators, and stakeholders can benefit from improved training and evaluation opportunities.

One of the greatest implications for social change this study is its possible contribution to reducing health disparities and improving access to health care providers. As McLeod, Klabunde, Willis, and Stark (2013) stated, physician satisfaction and their availability to provide care contributes to the quality of the health care delivery system. Greater physician satisfaction is associated with more appropriate prescribing practices, patient adherence, and greater patient satisfaction (McLeod, Klabunde, Willis, & Stark, 2013). Previous studies indicate that there is a relationship between physician satisfaction and patient satisfaction (Feldstein, et al., 2013). As the findings show, the less satisfied primary care providers are with the impact health legislation has on their practices, the fewer hours they are available to provide patient care. This study will influence health care policymakers to review current and future efforts to expand access to health care providers. Less satisfied PCP results in higher turnover, as well as higher indirect costs such as physician recruitment. This study can contribute to strategies aimed at improving

PCP satisfaction, which may lead to higher PCP retention rates, greater patient satisfaction, lower facility costs, improved access, and improved health status of patients who utilize these health care facilities.

This study can assist stakeholders in analyzing and evaluating existing health care access policies. Through policy analysis and evaluation, health care stakeholders can develop new legislation that will reduce the disparities in access to health services and providers. Understanding the sources of primary care physician dissatisfaction can improve not only health care access and quality but also reduce health care costs. Identifying the relationship between major health legislation and the adequacy and availability of health care providers to practice, can not only add to the scholarly literature library, but also improve access to health services, reduce other types of disparities, as well as improve the quality of services delivered.

Conclusion

Even as rates of uninsured patients begin to decline, primary care physicians' availability to deliver care remains an important topic in health care access, quality, and costs. This study's findings revealed important factors for researchers, health educators, health care policymakers, and other health care stakeholders. Access to health care services involves much more than expanding health insurance coverage or increasing the numbers of practicing physicians. While the other sources of physician dissatisfaction were not assessed, the study's finding indicate that many do not fully understand policies including the PPACA and are dissatisfied with the impact health legislation has on their practices. Since there is a positive correlation between physician satisfaction and the

number of hours they work each week, efforts designed to expand patients' access to health services must include addressing the sources of physician dissatisfaction.

Addressing sources of physician dissatisfaction may increase the number of patients they see daily. If physicians fully understand legislation such as the PPACA they may be prepared to address both the positive and negative impact of this legislation. This knowledge can then be incorporated into health policy development and evaluation. Also, increased knowledge and participation may be integral into reducing the pessimism identified in the results presented in Chapter 4.

Efforts to increase the number of practicing primary care physicians are evident in studies focused on the physician workforce (United States Department of Health and Human Services, 2013). As the quantitative data analysis in this study indicate; there is a significant difference in the perceptions of PCP of the importance of including PCP input in developing health policies between PCP who work fewer than 20 hours each week.

There was also a significant difference in satisfaction of the impact of health legislation on provider practice. There was a difference in the satisfaction of PCP who work between 30 and 40 hours each week, compared to those who worked less than 20 hours each week. Themes that emerged from the analysis of qualitative data pertaining to satisfaction showed that many will continue to work fewer hours each week, and the pessimism in the future of America's health care delivery system. Participants P1, P2, P3 and P4 who work fewer than 20 hours each week stated that they believed that PCP will continue to work fewer hours.

Declining PCP remuneration rates was a theme identified in the data obtained from 13 of the 15 interview participants. Similarly, 13 participants stated that efforts to control cost, quality, and access will continue to affect the supply of physicians. The findings that arose from this research indicate that PCP input is important in the policy development and evaluation processes, however, very few PCP fully understand legislation including the PPACA. Future studies are recommended to assess the actual impact this new legislation has on PCP practices, and recommendations provided to policymakers. Many PCP supported having an expanded knowledge base of resources to improve training and comprehension of legislation. This study's findings can contribute to not only developing more effective PCP satisfaction programs, but also strategies that can improve access to health care services and reducing disparities.

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Appendix A: Confidentiality Agreement

Name of Signer: Nadine Josephs

In collecting data for this research, *Disparities in Access: Assessing the Impact of Major Health Policies on Provider Practice*, a sequential explanatory mixed methods research design will be used to measure the relationship between disparities in health care supply and health care policy, and to explore strategies that should be incorporated into the development of health care access legislation. During this process I will have access to confidential information that should not be disclosed. I am aware of this and acknowledge that the information must remain confidential, and any improper disclosure of confidential information can be damaging to a participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge formation, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I am officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

By signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: Nadine Josephs **Date: April 28, 2014**

Appendix B: Consent Form for Participants / Invitation to Participate

Disparities in Access to Care: Assessing the Impact of Major Health Policies on Provider Practice

You may have already received an invitation to participate in this survey. If you have already completed and returned the survey, please accept my sincere thanks and discard this letter, as no further involvement is required. If you have not completed the survey, please take the time to consider participating in this important research.

You are invited to take part in a research study assessing the impact of major health policies on provider practice. You are invited as a possible participant because you are a primary care provider who has been practicing at least 5 years. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by researcher Nadine Josephs who is a doctoral candidate at Walden University.

Background Information:

The purpose of this study was to assess what impact health legislation has on your current practice in the United States, and to examine how this may contribute to disparities in access to care. Specifically, I will seek to gather information regarding (a) the relationship between health policies and the availability of primary care providers, and (b) the perceptions of primary care providers regarding reducing disparities in access.

Procedures:

If you agree to be in this study, you will be asked to:

- Complete a brief 10-minute survey.
- Indicate if you would be willing to participate in a 30-minutes telephone-based semistructured interview.
- If randomly selected to participate in the interview, a 15-minute follow up session will be done via phone to share preliminary findings and request feedback regarding the interpretation of the collected data.

Here are some sample questions:

- How important are primary care providers' input in developing health policies?
- How satisfied are you with the impact health legislation has on your practice?
- Have you received information or training on how to implement and analyze the effect the PPACA will have on your practice?
- Which health care policies can you easily identify to have the greatest negative effect on your practice?
- What advice would you provide to health care stakeholders currently focused on reducing disparities in access?

Voluntary Nature of the Study:
Your participation in this research study is strictly voluntary and will not affect you adversely in any way. Your identity will not be shared with any member of my doctoral committee, institution or medical bodies. No one at the American Medical Association or any other professional boards will treat you differently if you decide to not be in the study.

Risks and Benefits of Being in the Study:

There are minimal risks associated with participation in this study. However, in the event you experience stress or anxiety during your participation in the study, you may terminate your participation at any time. Also, you may refuse to answer any questions you consider invasive or stressful.
The potential benefit of participating in this study may come in the form of more effective health care policy evaluation and analysis processes that may improve primary care delivery, and reduce health access disparities.

Compensation:
There is no form of compensation for participation.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purpose outside of this research project. The researcher will not include your name or anything else that could identify you in the study reports. Data will be kept in a password protected file in a secured database. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher Nadine Josephs by phone at 561-289-0545 or by email at njosephs@hotmail.com. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210 and her email address is Leilani.edicott@waldenu.edu. Walden University's approval number for this study is **11-24-14-0289591** and it expires on **November 23, 2015.**
Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement.
In order to protect your privacy, I am not seeking your signature on the consent form and your completion of the survey would indicate your consent, if you choose to participate. Also, I have included 2 copies of the consent form. If you would like to only complete the survey, both consent forms are yours to keep, as return of the completed survey would be sufficient. If you are willing to participate in in the semistructured interview, please complete the information below and return a copy of the consent form with the survey in the self-addressed stamped envelope. You may keep the blank consent form for your records.

Date of consent _____
Participant's Telephone Number _____
Researcher's Signature *Nadine Josephs*
Please indicate your preferred day and time to contact you for an interview.
Sunday Monday Tuesday Wednesday Thursday Friday Saturday (please circle)
Time ___ am ___ pm

Appendix C: Semistructured Interview Protocol

Research Question 1: What is the relationship between health access legislation and the availability of primary care providers?

a. What are your views on the idea that patients are unable to obtain care due to health care providers being unwilling to offer health care services to the full scope of their training and education?
b. What do you perceive to be the main challenges in increasing the number of patients obtaining care in your practice?

What restrictions on primary care provider practice can be attributable to major state and federal policies improving access to care?

1. Which health care policies can you easily identify to have the greatest negative effect on your practice?
    a. How would you describe these effects on your practice?
    b. Does any of these policies affect your practice more than others?
    c. Can you share whether these restrictions are as a result of state or federal requirements?
2. How long have these policies been impacting how you deliver health services?
3. How do these restrict your availability to deliver care to patients?
    a. Are these restrictions impacting how available you are for your patients, your organization's profitability, and or the morale within your practice?
4. What are your perceptions on how these can be corrected?

Research Question 2: What are primary care providers' perceptions regarding reducing disparities in access?

a. What are your thoughts on the Healthy Program Initiative to reduce disparities in access to health care services?
b. What advice would you provide to health care stakeholders currently focused on reducing disparities in access?
c. In your opinion, how will these existing policies continue to restrict the availability of health care providers such as yourself?

Is there anything else you would like to share?

Thank you for your time and input. Please feel free to contact me if you have any other questions, thoughts, or need the results of this study.

Appendix D: Permission to Use Research Instrument

Subject : **RE: Contact Submission on physiciansfoundation.org**
Date : Thu, Feb 13, 2014 09:42 AM CST
From : **Danielle Belanger <dbelanger@gmafoundations.com>**
To : <nadine.josephs@waldenu.edu>

Good morning Nadine,

Thank you for your interest in the Foundation's work. From the Foundation's perspective, there is no formal procedure for approval of using aspects or
results of the study. Just please be sure to properly reference and cite the
foundation's survey in any written work that you develop.

Best of luck with your dissertation.

Regards,
Danielle

Danielle Belanger
Foundation Assistant
Physicians Foundation

-----Original Message-----
From: Nadine Josephs
[mailto:nadine.josephs@waldenu.edu]
Sent: Thursday, February 13, 2014 3:49 AM
To: dbelanger@gmafoundations.com
Subject: Contact Submission on
physiciansfoundation.org

Someone has submitted the contact form on physiciansfoundation.org. Here are
the details:

Date: 2014-02-13 04:49 AM

Attachments: 0
Collection Name: Contact Us
Name: Nadine Josephs
Email: nadine.josephs@waldenu.edu
Phone: 561-289-0545
Message: Good day,
I am currently a student completing my doctoral dissertation in Health
Services, with a dissertation topic “Disparities

in Access to Care: Assessing
the Impact of Major Health Policies on Provider
Practice". I came across the
Biennial Survey of America's Physicians"
published in 2012 and there were
aspects (questions) of the survey that I would
like to include in my study. My
question is, what is your formal procedure for
obtaining permission to use
aspects or results of your study. Your
assistance is greatly appreciated.

Appendix E: Codebook for Survey

Full variable name	SPSS variable name	Coding instructions
Knowledgeable in evaluating health policies	knlgevhp	1 = not knowledgeable, 5 = extremely knowledgeable
Interested in influencing policies	intinhp	1 = not interested, 5 = very interested
Involvement in health policy in past 2 years	invlhp2	1 = not involved, 2 = involved only through professional body, 3 = health policy advocate, 4 = involved only as citizen, taxpayer, parent
Importance of PCP involvement in policy development	imppcppv	1 = very unimportant, 5 = very important
Satisfaction with the impact of policy on practice	satimprac	1 - very dissatisfied, 5 = very satisfied
Factors that restrict the scope of services the most	restscsrv	1 = Reimbursement issues, 2 = lack of clinical autonomy, 3= Dealing with Medicare/Medicaid/Other government regulations, 4 = Non-clinical/administrative paperwork requirements, 5 = Uncertainty/Changes in health reform, 6 = Managed care regulations, 7 = Increasing costs of training and quality improvement requirements, 8 = Other
What extent do these restrictions affect the number of patients seen daily	exresaffpts	1 = No extent at all, 5 = To a large extent
Impact the following has on practice:		
a. Ongoing Medicare fee changes	onmedffch	1 = no impact, 5 = great impact
b. Implementation of Electronic Medical Records	impemr	1 = no impact, 5 = great impact
c. State and Federal insurance mandates	sfinsman	1 = no impact, 5 = great impact
d. Federal government intervention	fedgovint	1 = no impact, 5 = great impact
e. CMS sustainable growth rates estimates and calculations	cmssusgr	1 = no impact, 5 = great impact

f. Charity care requirements	chcrreq	1 = no impact, 5 = great impact
g. Medicaid's high member-to-PCP ratio	medmpcprt	1 = no impact, 5 = great impact
Barriers in developing health policies	bardevhp	1 = no barriers, 2 = lack of time, 3 = other priorities, 4 = lack of support from HCP, 5 = policy makers' attitudes/values, 6 = takes too long to see a difference, 7 = Uncertain outcome, 8 = frustration with the process, 9 = political influences, 10 = lack of money or other resources, 11 = cannot be involved due to employment/professional requirements 12 = probably won't make a difference in health care delivery, 13 = Other
Benefits of health policy development and evaluation	benhpdvev	1 = no benefits, 2 = create uniform standard of care, 3 = reduce health disparities, 4 = improve health care quality, 5 = improving a situation or issue, 6 = Being able to have HCPs comply (i.e. with laws), 7 = making a difference in patients' lives, 8 = potential to get resources (eg funding), 9 = being able to get involved/participate, 10 = other
What contributes to your dissatisfaction as a PCP	condispcp	1 = no dissatisfaction, 2 = decreasing autonomy, 3 = administrative hassles and non-clinical paperwork, 4 = low reimbursement rates, 5 = fee-for-service reimbursement requirements, 6 = lack of pricing transparency, 7 = price controls of fees and products, 8 = limited patient

		financial obligations, 9 = other
Received training/information on how to implement and analyze the effect PPACA will have on practice	trinppaca	1 = Yes, 2 = No
If Yes, how	yppaca	1 = professional journals, 2 = session(s) at a conference, 3 = workshop(s) devoted to PPACA, 4 = materials from professional organizations, 5 = professional colleagues, 6 = on-the-job experiences, 7 = mass media (tv, radio, newspaper, etc.), 8 = Other
Rate how likely the following would remove restrictions of PCP practices and reduce disparities		
a. Medicare voucher system	medvch	1 = not likely, 5 = extremely likely
b. More government regulation	mrgvtreg	1 = not likely, 5 = extremely likely
c. Less government regulation	lsgvtreg	1 = not likely, 5 = extremely likely
d. Increasing the number of PCP educational facilities	inpcpedfac	1 = not likely, 5 = extremely likely
e. Increasing the remuneration of PCP	inpcprem	1 = not likely, 5 = extremely likely
f. Revising reimbursement requirements without decreasing rates to PCP	Revrewodecr	1 = not likely, 5 = extremely likely
g. Expanded knowledge base and resources for improvement	expknwbandr	1 = not likely, 5 = extremely likely
h. Developing a health care system that places emphasis on value and benefits of PCP services	valbenof	1 = not likely, 5 = extremely likely
i. More effective and flexible charity care mandates	efflexccm	1 = not likely, 5 = extremely likely
Age	age	1 = <40, 2 = 40-44, 3 = 45-49, 4 = 50-54, 5 = >55
Sex	sex	1 = Female, 2 = Male
Geographical location of practice	geoloc	1 = rural, 2 = urban, 3 = suburban

State in which PCP practice	stprac	1 = Northeast (CT, ME, MA, NH, RI, VT), 2 = Mid-Atlantic (NJ, NY, PA), 3 = East North Central (IL, IN, MI, OH, WI), 4 = West North Central (IA, KS, MN, MO, NE, ND, SD), 5 = South Atlantic (DE, FL, GA, SC, NC, VA, DC, WV), 6 = East South Central (AL, KY, MS, TN), 7 = West South Central (AR, LA, OK, TX), 8 = Mountain (AZ, CO, ID, MT, UT, WY), 9 = Pacific (AK, CA, HI, OR, WA)
Employment setting	empl	1 = employed by public/government hospital, group or other public entity, 2 = employed by private hospital, group or other private entity, 3 = practice owner/partner/associate, 4 = educator, 5 = other
Average numbers of hours worked per week	avghrs	1 = 0-20, 2 = 21-30, 3 = 31 - 40, 4 = 41-60, 5 = >60
Average percent of time spent on no-clinical duties	pctnoncl	1 = none, 2 = less than 25, 3 = 25-50, 4 = >50
Professional affiliation	profaff	1 = County medical society, 2 = state medical society, 3 = AMA, 4 = American Osteopathic Association, 5 = Other