Concerns of Primary Care Clinicians Practicing in an Integrated Health System: a Qualitative Study

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BACKGROUND: Clinician well-being is a major priority for healthcare organizations. However, the impact of workplace environment on clinicians' well-being is poorly understood. Integrated health systems are a particularly relevant type of practice environment to focus on, given the increasing rates of practice consolidation and integration.

OBJECTIVE: To improve understanding of the concerns of primary care clinicians (PCCs) practicing in an integrated health system.

DESIGN: We analyzed free-text comment box responses offered on a national survey about care coordination by 555 PCCs in the Veterans Health Administration, one of the largest integrated health systems in the USA.

PARTICIPANTS: A total of 555 PCCs who left free-text comments on a national survey of care coordination in the VHA (30% out of 1862 eligible respondents). Demographics and coordination scale scores were similar between respondents who left comments vs. those who did not.

APPROACH: The data were coded and analyzed in line with the grounded theory approach. Key themes were identified by team consensus and illustrative quotations were chosen to illustrate each theme.

KEY RESULTS: VHA PCCs described some pressures shared across practice environments, such as prohibitive administrative burden, but also reported several concerns particular to integrated settings, including "dumping" by specialists and moral distress related to a concern for patients. Frustrations due to several aspects of responsibility around referrals may be unique to integrated health systems with salaried clinicians and/or where specialists have the ability to reject referrals.

CONCLUSION: PCCs in integrated health systems feel many of the same pressures as their counterparts in non-integrated settings, but they are also confronted with unique stressors related to these systems' organizational features that restrict clinicians' autonomy. An understanding of these concerns can guide efforts to improve the well-being of PCCs in existing integrated health systems, as well as in practices on their way to integration.

KEY WORDS: Veterans; primary care; integrated health systems; clinician well-being.

INTRODUCTION

Stressed and dissatisfied clinicians are more likely to be depressed, provide worse quality of care, cut down their hours, or leave medicine altogether, exacerbating existing workforce shortages.[1–4] In recent years, clinicians and policymakers have rallied around the Quadruple Aim, which adds clinician well-being to the Institute for Healthcare Improvement Triple Aim for healthcare quality (population health, healthcare costs, and patient experience).[5, 6] Research suggests that clinician well-being is negatively affected by organizational factors, such as excessive workload, insufficient control over work processes, heavy clerical burdens, misalignment with leadership's values, inadequate support and resources, and lack of collaborative working relationships.[7–16] However, as a recent literature review highlights, the effect of organizational factors associated with different *types* of practice environments is poorly understood.[10]

Clinician well-being in integrated health systems (or integrated delivery systems) is especially relevant given the accelerating trend toward practice consolidation and integration.[17] We use the term "clinicians" to describe physicians and advanced practice providers, including nurse practitioners and physician assistants, in primary care ("primary care clinicians" or "PCCs") and specialty care ("specialists"). Few direct comparisons of factors that affect the well-being of clinicians in integrated vs. non-integrated settings have been published, and findings are mixed. One study found that physicians in integrated systems report higher levels of personal accomplishment and lower levels of depersonalization than their counterparts in minimally integrated settings.[18] In another survey, primary care physicians who work

in settings with an organizational emphasis on care quality (rather than productivity) also report a greater sense of satisfaction,[12] which suggests that clinicians in large, integrated systems may be at an advantage, given that these systems generally possess a greater capacity to pursue quality improvement initiatives.[19, 20] However, abundant evidence also suggests that clinicians who perceive themselves as lacking control over clinical and workplace issues may experience higher dissatisfaction and burnout rates.[8, 13, 21, 22] It is possible, therefore, that a relative lack of autonomy in integrated settings, and especially in highly integrated systems, may have a deleterious effect on clinicians' well-being. Indeed, several studies have found a greater sense of control over the work environment to be associated with greater job satisfaction and lower burnout rates.[8, 23] In sum, research is still in its early stages, and a lot remains to be learned about the impact of common organizational characteristics of integrated systems on clinician well-being.

A better understanding of clinician experiences in integrated health systems would inform efforts to ameliorate clinician distress both in the established systems and in practices on their way to integration.[24, 25] In this paper, we address this gap by turning the spotlight to the experiences of a nation-wide sample of primary care clinicians (PCCs) in one of the largest integrated systems in the USA, Veterans Health Administration (VHA). PCCs are a professional group of particular concern, given their alarmingly high burnout rates.[26–29] Because VHA has certain distinguishing characteristics that set it apart, our findings may have greatest relevance to PCCs who practice in fully integrated systems with salaried clinicians and/or where specialists have the ability to reject referrals. However, VHA also has many features in common with other large integrated systems, such as Mayo Clinic, Kaiser Permanente, and Intermountain Health System. These include an overarching organizational structure, a shared electronic health record, and a focus on standardization, quality improvement, and rigorous documentation standards.[30–35] Several of these organizational features impose limitations on clinicians' autonomy, which, in turn, may have an impact on their work life and well-being.[36, 37][26–29] Therefore, many insights presented below have a broader relevance to clinicians in other integrated health systems.[38]

METHODS

The study setting is the Veterans Health Administration (VHA), a large integrated health system. VHA employs over 300,000 healthcare professionals and provides care to more than 9,000,000 patients at 1255 facilities.[39]

The Coordination of Specialty Care-Primary Care Provider Survey (CSC-PCP) was administered online in April 2018 to 7979 VHA PCCs.[40] Originally titled CSC-PCC (Coordination of Specialty Care-Primary Care Clinician), the survey was renamed by the survey study PI prior to final acceptance of the related manuscript. We retain the term PCC in this

manuscript to avoid hierarchical connotations associated with the dichotomy of "PCP/specialist."

The CSC-PCP survey explored PCC perspectives on relationships, roles and responsibilities, data transfer, and communication with respect to specialty care providers, as part of a larger study of care coordination between PCCs and specialists in VHA (see Appendix 1 for additional details on the survey content).[38, 41, 42] All VHA PCCs, i.e., physicians and advanced practice providers (including nurse practitioners and physician assistants), were eligible to participate. Non-respondents received a total of 3 reminders at 4–5-day intervals.

After 23 PCC respondents contacted the research team with additional thoughts to share, we appended a free-text comment box to the survey, phrased in the following way: "Please use this space to voice your opinion on any other issues related to coordination with specialty care that may not have been addressed in the survey. There is no word or character limit on your comments."

Ninety-five respondents accessed and filled out the survey before the comment box was added. The modified version of the survey (with the free-text comment box) was accessed by 1957 respondents. Of the 1862 who were eligible to complete the survey after responding to screener questions, 555 (30%) left a response in the comment box, including 328 physicians and 203 advanced practice providers (see Table 1). The overall survey response rate (counting respondents who participated before and after the addition of the comment box) was 23% ($N = 1862$), consistent with results from other VHA online clinician surveys.[38, 43, 44] The comments ranged in length from a sentence to several paragraphs and were marked with a heightened emotional tone. Although the survey was focused on care coordination, it had opened a path for VHA PCC respondents to talk about a much wider spectrum of issues.

Table 1 Demographic Characteristics of Survey Responders

	Comment box responders ($N = 555$)	Comment box non-responders ($N = 1307$)
Degree		
MD or DO	328 (59.1%)	728 (55.7%)
NP	153 (27.6%)	342 (26.2%)
PA	19 (3.4%)	76 (5.8%)
Other	31 (5.6%)	97 (7.4%)
Missing	24 (4.3%)	64 (4.9%)
Location		
VAMC*	207 (37.3%)	503 (38.5%)
CBOC†	230 (41.4%)	582 (44.5%)
HBPC‡	81 (14.6%)	127 (9.7%)
Other	13 (2.3%)	31 (2.4%)
Missing	24 (4.3%)	64 (4.9%)
Age		
≥ 50 years	195 (35.1%)	478 (36.6%)
< 50	130 (23.4%)	266 (20.3%)
Missing	230 (41.4%)	563 (43.1%)

*VA Medical Center
†Community-Based Outpatient Clinic (VA outpatient clinic affiliated but not physically co-located with a VA Medical Center)
‡Home-Based Primary Care (in-home support for Veterans with complex conditions who may have difficulty with regular clinic visits)

Demographics and scores on multi-item scales measuring six domains of coordination were similar between respondents who left comments vs. those who did not (see Tables 1 and 2).

The research team included six health services researchers with backgrounds in anthropology (EA), social work (AS), internal medicine and infectious diseases (GF), survey research (MM), psychology (JW), and endocrinology and public health (VV). Data analysis was led by EA, an experienced qualitative researcher, with participation by AS and VV who each have experience in qualitative research methods. Our analytical approach, informed by grounded theory,[45] prioritized codes and themes emerging from the data over a priori constructs. We also followed methodological precedents for rigorous qualitative analysis of free-text survey comments.[46–49] After three team members (EA, AS, VV) coded a sample of 35 comment box responses independently, an initial codebook was created through discussion and consensus. It was refined iteratively over several rounds of independent and collective coding, as coders introduced new codes, created sub-codes,

clarified definitions of individual codes, and changed hierarchical relationships between codes. After finalizing the codebook, the same three team members continued to code the comments independently in NVivo 12 software (QSR International), meeting regularly for discussion. All 555 comments were coded, with theoretical saturation reached in the process. The full team then generated key themes through consensus and selected representative quotations to illustrate each theme. The study was approved by the Bedford VA Institutional Review Board. Additional details about the data analysis methodology are included in Appendix 1.

RESULTS

We identified four prominent themes across PCC comments: (1) struggle over referrals, (2) "dumping" by specialists, (3) administrative burden, and (4) moral distress. Quotations are followed by the respondents' study ID numbers. For additional exemplary quotations, see Appendix 2.

Struggle over Referrals

In the VHA, referrals ("consults") are sent to specialty services through the shared EHR. To promote efficient utilization of specialty care in the VHA, specialty services review the referrals and either schedule them, decline them, or request additional information.[50] In our survey, comments about specialty referrals were common. In contrast to the collegial connotation of the term "care coordination," several PCCs use the metaphors of struggle, resistance, and game-like competition to describe their experiences, frequently portraying specialists as unsympathetic and uncooperative:

> It is a constant battle to make sure patients are getting follow up appointments… (123). The specialty services… treat this consult process like a game. They [nitpick] & find the slightest miniscule, typically inexcusable and ridiculous reason to cancel your consult request, & then have the audacity to comment that you should order a new consult (455).

In this largely contentious context, some PCCs perceive specialists who refuse to accept referrals as, in effect, preventing referring providers from exercising their clinical judgment:

> The ability of the specialty clinics to cancel consults requested by primary care providers without seeing or evaluating the patient is inappropriate. When a consult has been placed, it serves as an indicator that the PCP has reached the limits of their scope of care and <is> requesting specialty guidance (76).

Some PCCs also opine that specialists reject referrals in an improper, disrespectful fashion:

Table 2 Mean Scale Scores for Survey Responders (N = 1862)

Question	Comment box responders (N = 555)	Comment box non-responders (N = 1307)
Care coordination scales[§]		
Relationships and collaboration	5.25 (365) (Std = 1.15)	5.21 (819) (Std = 1.15)
Communication	4.96 (295) (Std = 1.51)	4.94 (693) (Std = 1.45)
Role agreement	5.55 (418) (Std = 1.04)	5.58 (929) (Std = 1.04)
Data transfer	6.04 (355) (Std = 1.05)	6.07 (794) (Std = 0.98)
Role clarity	5.05 (N = 361) (Std = 1.29)	4.97 (826) (Std = 1.27)
Making referrals	3.50 (429) (Std = 0.83)	3.43 (969) (Std = 0.90)
Satisfaction scales[∥]		
Satisfied with job	3.58 (345) (Std = 1.09)	3.57 (777) (Std = 1.07)
Satisfied with coworkers	3.96 (345) (Std = 1.00)	3.99 (778) (Std = 0.97)
Satisfied with organization	3.22 (345) (Std = 1.11)	3.22 (779) (Std = 1.11)
Burnout scales[¶]		
Feeling burned out	4.32 (343) (Std = 1.86)	4.39 (776) (Std = 1.79)
Feeling cynical/detached	3.44 (343) (Std = 2.10)	3.64 (775) (Std = 2.07)
Feeling accomplished	5.49 (342) (Std = 1.63)	5.57 (777) (Std = 1.56)

[§]*Responses to individual items assigned to the Making Referrals scale are on a 5-point frequency scale from 1 (Never) to 5 (Always). Responses to items assigned to the other scales are on a 7-point frequency scale from 1 (Never) to 7 (Always). All items ask about experiences in the last last 3 months. Scale scores are calculated using data from respondents whose data are non-missing on at least half of the items in that scale. The scales are scored as the simple average of the scores for the items assigned to that scale and have a theoretical range from 1 to 5 (Making Referrals scale) or 1–7 (for the rest of the scales)*

[∥]*Satisfaction item response scales: 1—very dissatisfied, 2—dissatisfied, 3—neutral, 4—satisfied, 5—very satisfied*

[¶]*Burnout item response scales: 1—never, 2—few times a year, 3—once a month or less, 4—few times a month, 5—once a week, 6—few times a week, 7—every day*

The specialists often treat consulting physicians in a condescending manner. <…> Snippy or sarcastic comments back on a consult before the consult is discontinued are unprofessional and unwarranted (326).

E-consults (electronic consultations) are an asynchronous consultation modality used in the VHA and some other health systems to expedite care by obtaining specialist advice without a face-to-face referral. These are described by some PCCs as a way for specialists to avoid seeing patients:

Some specialists too freely convert consult orders into E-consult orders in inappropriate situations, in what appears to be an attempt to limit the number of patients who are scheduled for face-to-face visits in their clinic (52).

Similarly, service agreements and referral templates are viewed by some PCCs as tools wielded by specialists to restrict, rather than facilitate, PCCs' ability to request referrals:

The consultants on the most part HIDE behind their service agreements. Labs and imaging that is not avail[able] to any of my vets could get completed at the <consultant's> facility same day as seen and the consultants REFUSE and cancel consult after consult (253).

Interestingly, some PCCs attribute the contentious nature of specialty care referrals to organizational features that discourage specialists from accepting referrals, in contrast to the private sector where specialists are incentivized to do so:

New to VA from private sector. Amazed at how easily and frequently specialists reject referrals <…>. Sometimes have to place referral requests multiple times. Not so in the private sector where specialists rely on PCP for 'business' and referrals (355).

While some PCCs did report positive experiences, referrals were generally portrayed as a source of contention, attributed to the specialists' unprofessionalism and gatekeeping or to structural disincentives.

"Dumping" by Specialists

A related concern expressed by many respondents involves the perceived "dumping" of tasks by specialists. Some PCCs report that specialists impose an unreasonable volume of workup and testing to be completed in primary care prior to specialty care appointments:

The amount of things dumped on primary care is mind-blowing. When trying to place consults, the services

want a plethora of things done first to which we have no access (229).

Similarly, the conversion of face-to-face referrals to e-consults is also described by some as dumping:

They flip all the consults to [e-consults] and… throw all the work back on primary care to do extensive workups that are beyond our training or comfort level. There have been numerous complaints but nothing is done. Although primary care is the backbone of the VA we are treated like dirt to do the specialists bidding (195).

Many PCCs also describe a growing burden of tasks being dumped on them that they perceive as being within the purview of specialists, including requesting tests, ordering medication, and scheduling follow-up specialty care appointments:

[Specialists] have no sense of responsibility towards the patients that are referred to them. Everything is dumped on Primary care <…> follow up appts not scheduled, meds prescribed by them not refilled, despite [EHR] reminders to set [follow up] for patients, no action taken (235).

For numerous PCCs in our dataset, this prohibitive workload spills outside of the normal working hours, leaving them feeling overwhelmed:

I routinely work an extra 20 hours of unpaid overtime each week, after hours and from home, in order to do the tasks for my patients that are left undone by specialists and other healthcare staff members (52).

It is not only the heavy workload that some PCCs deem problematic, but the growing share of tasks perceived as low-level or clerical:

Primary Care spend over half their time doing computer work consultations rather [than] providing quality care to veterans (105).

Some respondents also report that they feel like specialists' subordinates rather than equal partners:

Specialty service providers at our facility do not utilize Primary Care Providers as partners in co-management of patient care but rather… as CLERKS to do their clerical work (443).

In sum, respondents' concerns about dumping largely derive from their perception that many tests related to initial referrals and ongoing care should be the responsibility of

specialists rather than delegated to PCCs. In other words, some PCCs see specialists as unwilling to equitably share ownership for patient care.

Administrative Burden

In addition to their frustration with workload shifting by specialists, PCCs expressed concerns related to the growing administrative burden, more generally. The lack of protected time to address administrative tasks came up repeatedly as a prominent, system-level issue:

> No one in this entire… system <…> have any clue about how much work is piled on PCP. <…> No administrative time is given for coordination, paperwork, phone calls, view alerts. We are given 30 minutes each day. <…> You are burning out your PCPs or not paying them enough for the amount of work expected. Metrics are not capturing true workload of all paperwork (295).

Some of the complaints highlighted the disruptive effect of EHR alerts and reminders on clinical workflows and patient-provider rapport:

> The reminders often pop up without us being trained on how to use them and when you see a patient with lots of problems and only 1/2 hour in which to see them, and the reminders take up 10-15 minutes (esp. if a new pt.) the pts. are very mad and blame me, the doctor stuck in the middle of meeting VACO's never ending metrics!!!!! (505).

Other PCCs lamented an erosion of their professional identity caused by the rising documentation workload:

> I worked in private practice where I actually did doctoring. Here… I do very little doctoring, mostly I'm a secretary, typist, and I have no authority.[78]

As one respondent describes, administrative burden remains stressful even when the clinical appointment workload is reduced:

> I used to be able to see 17-21 veterans per day and not be stressed. I now am very stressed to see 8. I spend 90% of my day entering data into the computer. This is not what I trained for (499).In sum, respondents describe an exhausting workload and a workflow that prioritizes clerical tasks over clinical care, giving rise to feelings of disrespect and erosion of professional identity.

Moral Distress

Finally, many of the PCCs express a sense of moral distress related to the perceived impact of the organizational issues described in preceding sections on patients and patient care. Some of these concerns relate to the perceived lack of timeliness in accessing specialty care:

> [T]oo often patients are not seen timely. The reason for consult is not addressed and sometimes outright denial to see patient (from certain departments) (376).

Some respondents also describe themselves as "stuck" in the middle between uncooperative specialists and angry, frustrated patients who are unable to obtain a face-to-face appointment:

> Our challenge here is that some specialties are quick to decline consults or put too many pre-requisites before they accept a patient and we have to face the frustrations of the veterans when they are expecting to be seen by a specialist (97).

Other PCCs feel that their *own* ability to provide high-quality care is compromised by the workload:

> I could see more pt's easily. Provide more and better care, if I were not spending so much time in clerical activities... Is it really effective use of employee who has spent 7 years after college and 11 years after high school to spend typing in meds and re-submitting consults that should not have been discontinued <…>?.[44]

Although the original survey asked respondents to focus on experiences with care coordination in the VHA, some of the comments were related to coordinating care with "community" (non-VHA) providers. At the time of the survey, the VHA was implementing the Veterans' Choice Act, intended to facilitate the access of Veterans facing long wait times and/or travel distances to care in the community (replaced in June 2019 by the VA MISSION Act with a similar focus). Amidst these policy changes, some PCCs express concern that patients do not receive community care referrals as promptly and frequently as needed:

> The problem is coordinating care with specialty care for patients going outside the VA system for care. <…> I have seen delays related to timely referrals outside the VA causing patient harm. It is indefensible, inexcusable, and immoral (293).

Others, by contrast, are worried about the effects of the growing access to community care, perceived as subpar, on patients. One particularly critical respondent wrote:

> I can say [WITHOUT] HESITATION that removing specialties from the VA and placing that care in the hands of outside providers would be a DISASTER. Outside physicians resist treating VA patients NOW

because we have a complex population with numerous co-morbidities. <…> Please, I implore those in power to leave the specialties within the VA (436).

Overall, many respondents express a sense of moral distress due to their perception that they are too often unable to deliver or arrange for the care that they think they patients should have.

DISCUSSION

Through an analysis of free-text survey responses from a sample of VHA PCCs, we identified a number of key concerns, reflecting a mix of pressures experienced by PCCs across practice settings and stressors that may be particular to integrated systems.

PCCs in our sample report struggling with a heavy administrative burden that is increasingly marginalizing direct patient care. The growing rates of clinician stress, dissatisfaction, and burnout due to time pressures, heavy documentation burden, loss of professional autonomy, and decreased control over practice environment are not unique to the VHA and have been reported widely.[51–53] A general sense of being undervalued, as evidenced by salary inequity, perceived lack of prestige, and even the language used to refer to clinicians (i.e., some are "special"), is common among primary care clinicians and exacerbates dissatisfaction.[54–57] These shared stressors can be addressed through such measures as adopting EHR systems designed with clinicians' needs in mind,[58, 59] a wider use of clinical scribes,[60, 61] implementing team-based care,[9, 62, 63] and providing protected administrative time.[64] To counteract the erosion of clinicians' professional identity, stakeholders might create and expand opportunities for PCCs to pursue professional development and nurture relationships with other clinicians.

Other themes identified in our study appear to be more specific to practice in integrated health systems. One phenomenon that may be unique to integrated health systems is the perceived extent of "dumping." Qualitative studies of PCC experiences in the UK's National Health Service have identified dumping by specialists as a grievance,[65, 66] and a comparative study of 16 US health systems with shared electronic referral and/or consultation systems reported that some PCCs perceive a shared EHR as facilitating the transfer of work tasks by specialists.[67] It is not surprising that some specialists shift the burden of work (i.e., "dump") onto their PCC colleagues given the ease of delegating tasks through the shared EHR, the often ambiguous organizational division of roles and responsibilities,[42] the rising productivity pressures,[68] the lack of financial incentives to see patients,[69, 70] and the lack of quality indicators for specialists.[71] It is important to look beyond the potential motivation of individual specialists to the structural features of integrated systems that facilitate *and* motivate dumping. We recommend that stakeholders ensure that the additional workload of PCCs due to work-shifting by specialists is equitably recognized and compensated. Jointly negotiated service agreements would clarify division of responsibilities between specialists and PCCs by promoting a shared understanding of such details as what goes into the consultation request or into the specialist's response note, as well as who should be responsible for carrying out the recommended actions. These agreements could also introduce incentives for specialists to maintain ownership over some categories of patients, thus alleviating the PCC burden and potentially improving patient care quality.

Another finding appears to be most relevant to integrated systems where clinicians are paid a salary and specialists have the ability to reject or convert referrals. Literature on specialty referrals often focuses on the lack of timely and sufficient communication from specialists following the referral,[72–74] but this issue is less prominent in the context of a shared EHR. Rather, the referral-related complaints in our study were primarily related to the perception of inappropriately rejected or converted referrals.[72–74] This finding is consistent with those of earlier surveys of VHA PCCs on referral communication.[42, 50] Our study builds on these prior findings by elucidating how PCCs make sense of rejected referrals. Specialists salaried in integrated health systems, unlike their private sector counterparts, do not have an inherent incentive to solicit referrals from PCCs. When PCCs perceive specialists as hostile gatekeepers, this creates an adversarial dynamic between PCCs and specialists that threatens clinician well-being and could ultimately undermine care quality. While the rejection of some referrals may be inevitable, the negative impacts described here could be mitigated by ensuring agreement between services on referral criteria[75] and incentivizing specialists to provide detailed and respectful justifications for rejecting referral requests. Surveys such as the Coordination of Specialty Care-Primary Care Provider (CSC-PCP)[40] and the Coordination of Specialty Care-Specialist (CSC-Specialist)[38, 41] can be used to capture both referring and consulting providers' perspectives on the quality of inter-clinician communication and relationships and subsequently guide improvement efforts.

Finally, we identified the theme of moral distress, or the anguish experienced due to perceived inability to act in accordance with one's ethical ideals,[76–78] in the survey comments. PCCs in some integrated health systems are structurally positioned to act as gatekeepers to care, while also facing gatekeeping behavior by specialists. In this context, PCCs may feel that they are prevented from providing the best care possible due to constraints imposed by the system. Distinctive from burnout, this form of moral distress may be a particularly corrosive unintended consequence of practicing primary care in an integrated health system, but it also reminiscent of the moral distress among clinicians in managed care systems forced to "ration" healthcare on the basis of deservingness[79] and the dissatisfaction reported by physicians across different

types of practice environment about payers refusing to cover necessary medical services.[16]

This study has limitations. Most fundamentally, our findings may appear to have limited generalizability beyond the VHA. One of the most distinctive features of the VHA, shared by only some integrated health systems, is the ability of specialists, who are salaried and therefore do not have inherent financial incentives to see patients, to reject referrals. However, all integrated health systems strive to provide efficient care, wherein patients are seen by specialists only as appropriate.[35] The downside of this mission to avoid unnecessary care is that PCCs, unable to override a referral rejection, may experience this as a slight to their autonomy. Therefore, while we concede that the findings of this study may be most closely applicable to large, fully integrated health systems where providers are salaried and/or specialists have the ability to reject referrals, we contend that they also have a broader relevance to all integrated settings where clinicians' autonomy may be constrained.

Other limitations need to be acknowledged. Our analysis, by design, did not include the perspectives of PCC survey participants who did not leave responses in the comment box or of specialists. However, there were no differences in self-reported burnout, satisfaction, or scores on survey care coordination scales among PCCs who did vs. did not leave comments (Tables 1 and 2). Additionally, we did not discuss any interdisciplinary differences in PCC experiences. Although our analysis did not detect any differences between survey responses left by advanced practice providers vs. their physician counterparts, interdisciplinary differences in PCC experiences do exist[14, 80–82] and warrant closer study. It is also possible that the study underemphasized differences between PCCs at different VHA sites and overlooked some of the issues faced by non-VHA clinicians that are not salient in the VHA context. Finally, because the survey focused on the topic of care coordination, many (although not all) of the identified themes relate to care coordination and/or relationships with specialists, more broadly. These limitations notwithstanding, our analysis, which drew on a large, national data sample and employed rigorous qualitative data analysis procedures, provides insight into many issues that appear to be regularly encountered by PCCs across integrated health systems and some that may be characteristic of primary care settings at large.

CONCLUSION

VHA PCCs report some experiences that may be shared by their counterparts in non-integrated practice settings, such as a prohibitive workload and a documentation-heavy workflow. Other challenges, including conflicts surrounding specialty care referrals, frustrations with "dumping" of work by specialists, and a specific form of moral distress, seem particular to integrated health systems, especially those with salaried clinicians and/or where specialists have the ability to reject referrals. Integrated health systems and practices in the process of integration would do well to recognize these dangers and adjust their policies to avoid these negative effects among their PCCs.

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Compliance with Ethical Standards:

The study was approved by the Bedford VA Institutional Review Board.

Conflict of Interest: *The authors declare that they have no conflict of interest.*

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