



*Solo & Small Group Practice
Serving Underserved & Diverse Patient Populations*



*Medical Leadership Council Presentation
May 28, 2008*



These projects were funded by the
The California Endowment



Project Areas



Technical Assistance Project – *Caring for Diverse Populations*

Language Access Issues in Solo & Small Medical Practices in Santa Clara County

Quality Improvement in Solo/Small Group Practice



Technical Assistance Project – *Caring for Diverse Populations*



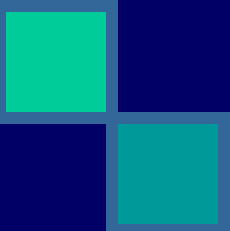

NCQA Project – CMA Foundation served as the lead organization in California for the state pilot project.

Project Focus –

- **Healthcare Disparities Reduction**
- **Quality Improvement**
- **Solo/Small Group Primary Care Practices**



TAP Project Purposes

- Understand & address barriers to care for minority patients in small primary care practices.
 - Provide demonstration grants to solo/small group practices to improve care for minority patients & learn what is required to make and sustain quality improvement.
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TAP Project Approach

- **Objective:** Stimulate interest among practices to address CLAS/Healthcare Disparities and identify feasible strategies for small practices.
- **Grants of up to \$25,000 to 11** small, independent primary care practices in CA with a range of diverse or minority populations.
- **Method:** Practice-based 12-month Quality Improvement project to improve care for diverse/minority population.
- **NCQA & Partners** provide practices technical assistance addressing quality improvement and CLAS/Disparities.



TAP Project Lessons Learned

Quality improvement takes longer than one year to achieve.



Smaller practices have fewer resources to devote to a change process.

Feedback is important when a change is tried.

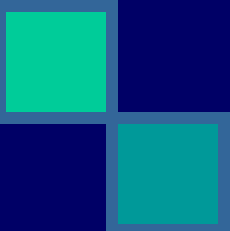
It was hard for practices to take on HIT and QI simultaneously.



When staff is part of the improvement process & understands their role in making the practice better, the effort to change and improve is stronger.




TAP Project Lessons Learned



Communication between the physician and staff about practice improvement, and how the office is functioning is central to success.

A staff champion within the practice is critical for sustaining practice improvement.



The closer the proposed quality improvement focus was to the core of the practice's mission, the more likely it is to be sustained, beyond the life of the quality improvement project.

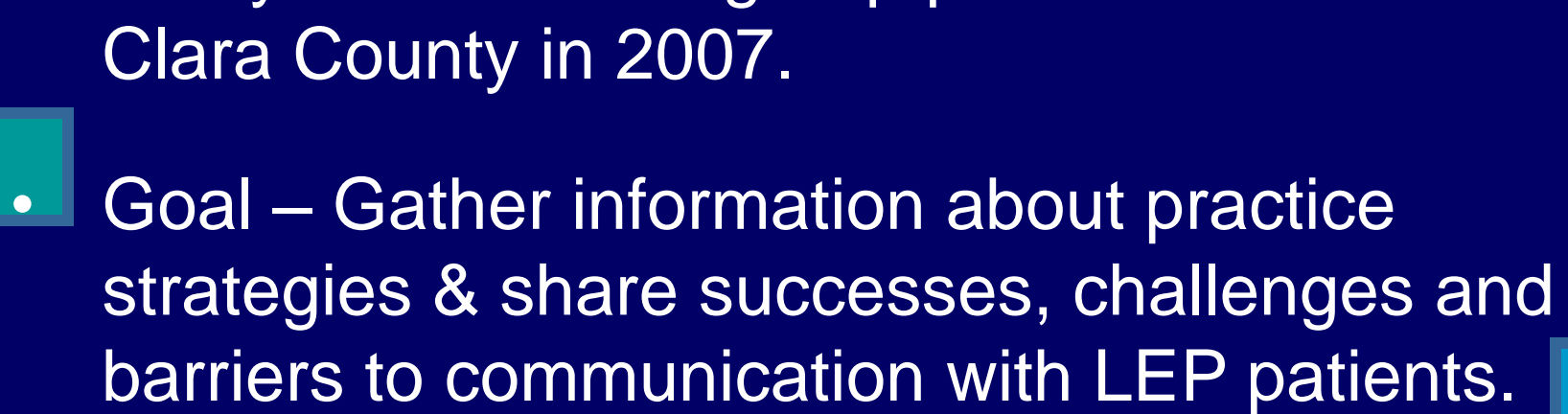


Language Access Issues in Solo & Small Medical Practices in Santa Clara County:

*How Some Physicians are Facing the
Challenges*



Project Focus

- Study of solo/small group practices in Santa Clara County in 2007.
 - Goal – Gather information about practice strategies & share successes, challenges and barriers to communication with LEP patients.
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Project Approach

- 42 physicians in both primary care & other specialties.
- Physicians participated in an in person or telephone interview or completed an on-line or mailed questionnaire.
- The questionnaire gathered information regarding the challenges they face in providing care to LEP patients.



Key Findings

Physicians participating in the study treat patients speaking more than 30 different languages.

Physicians voiced their commitment to provide quality care to all their patients regardless of language or cultural background.

Considerable variation exists among physicians own assessment of how well they can accommodate their LEP patients and how confident they were that they communicated effectively with them.

Training was not provided to physicians in medical school or residency in how to work with patients who speak a different language.

Quality of care issues arose more with their LEP patients.



Key Findings

The majority of physicians participating in the study spoke more than one language.

Staff play a key role in LEP communications.

Language skills was not a key decision among physicians in hiring staff. Family members were relied on to some degree to communicate with LEP patients.

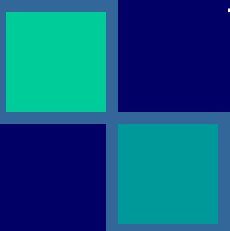
Limited financial resources make expenditure of additional resources for LEP patients difficult or impossible. Few used trained interpreters.

Physicians are generally aware of requirements concerning language access, but unfamiliar with specific guidelines or recommendations.



Recommendations

Explore how medical school curricula can be changed to include training re: multilingual/multicultural practice.



Publicize multilingual medical resources available to physician practices & CMA On-Call information on legal requirements for language access.

Publicize health plan compliance plans in response to DMHC & DOI language access regulations.



Create stronger partnerships to distribute multilingual health education materials.

Support broader opportunities for healthcare interpreter training.

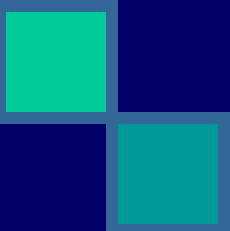


Strengthening the Private Practice Safety-Net


*Quality Improvement
in Solo and Small Group Practice*



Project Purpose



Formation & implementation of strategies to support the sustainability of primary care ethnic physician solo/small group practices to insure access to care for safety net patients.






Population

- Ethnic solo and small group practitioners working in primary care
 - **Solo and small group practices (SSGs):** physician-owned practices of 1-6 physicians
 - **Ethnic physicians:** physicians of African American, Hispanic, Asian, South Asian, or Pacific Islander descent.
 - **Primary care:** general practice, pediatrics, family practice, internal medicine, and obstetrics/gynecology.
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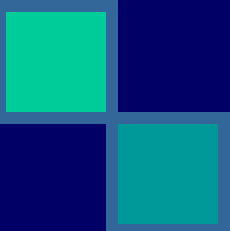


Regions Included

- Bay Area Counties – Alameda, Contra Costa, San Francisco, San Mateo, Santa Cruz & Santa Clara
 - Los Angeles County
 - Central Valley Counties – San Joaquin, Stanislaus, Fresno, Tulare and Kings
 - San Diego County
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Defining the Safety Net



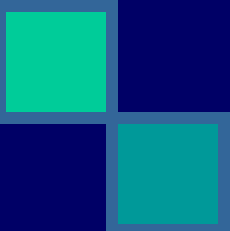

The IOM defines the Safety Net as “Those providers that organize and deliver a significant level of healthcare and other related health services to uninsured, Medicaid and other vulnerable populations.”

According to the W.K. Kellogg Foundation, “private physicians may well be the invisible giant of the nation’s healthcare safety net.”





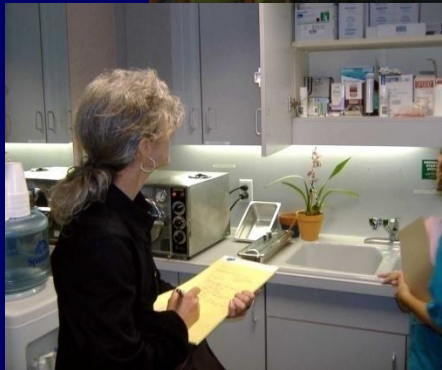
QISS Project Activities

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- Literature review
 - 18 focus groups with physicians
 - 4 discussion groups with healthcare consumers
 - 40 site visits with solo and small group practices
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Data Collection

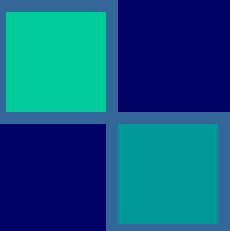



- **Physician Focus Groups**
- **Pre-visit Questionnaire:**
Mailed to practice and faxed back to PRI
- **Office Manager Survey:**
In-person interview, 1.5-2.25 hours
- **Physician Interview:**
In-person interview, 0.5 hours
- **Observation:** ethnographic observation in physician's waiting room, 1-3 hours
- **Patient Discussion Groups**



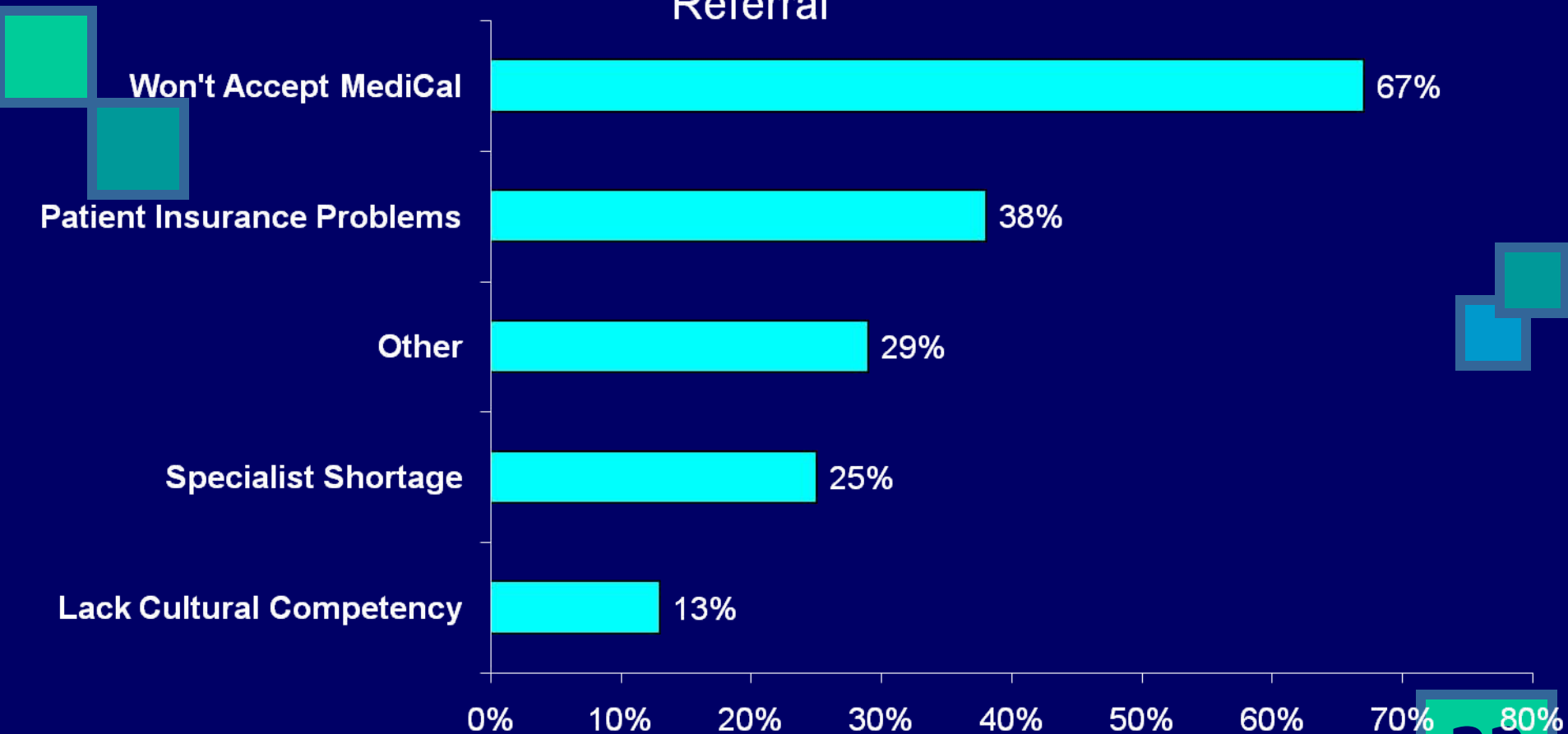


The Attraction of Solo/Small Group Practice

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1. Independence; to “be my own boss”
 2. To serve a specific community
 3. To be free to provide a higher standard of care
 4. Convenience or “It just sort of happened”
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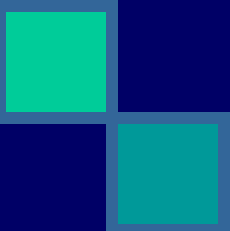

Referral Networks

24 out of 40 Have Experienced Difficulty with Specialist Referral






Staffing Overview

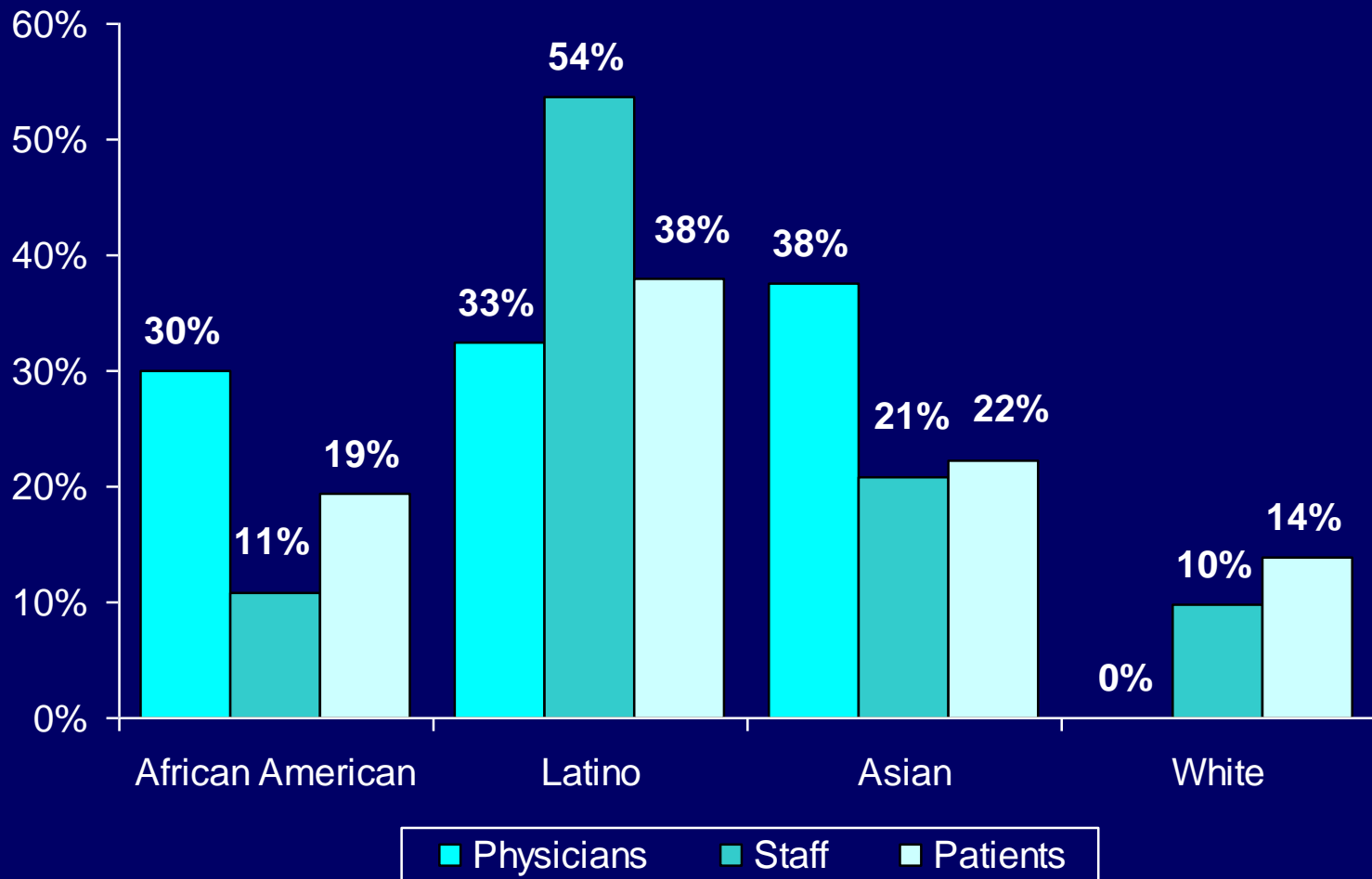
- 267 staff listed
 - 62% of staff receive benefits
 - 84% are full-time/16% are part-time
 - Median length of employment: 3 years
 - Range: 0-26 years
 - Median number per practice: 5
 - Range is 1-23 staff per practice
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Staffing Challenges

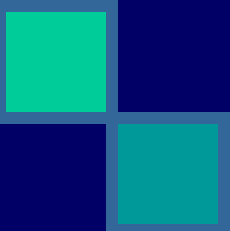

- Inability to afford the type or # of staff needed
 - Lack of qualified staff/attitude problems
 - High turnover, esp. among MAs
 - **Difficulty finding staff that “fit” with the patient population**
 - Difficulty finding qualified bilingual staff
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Patient/Physician/Staff Concordance - Race/Ethnicity

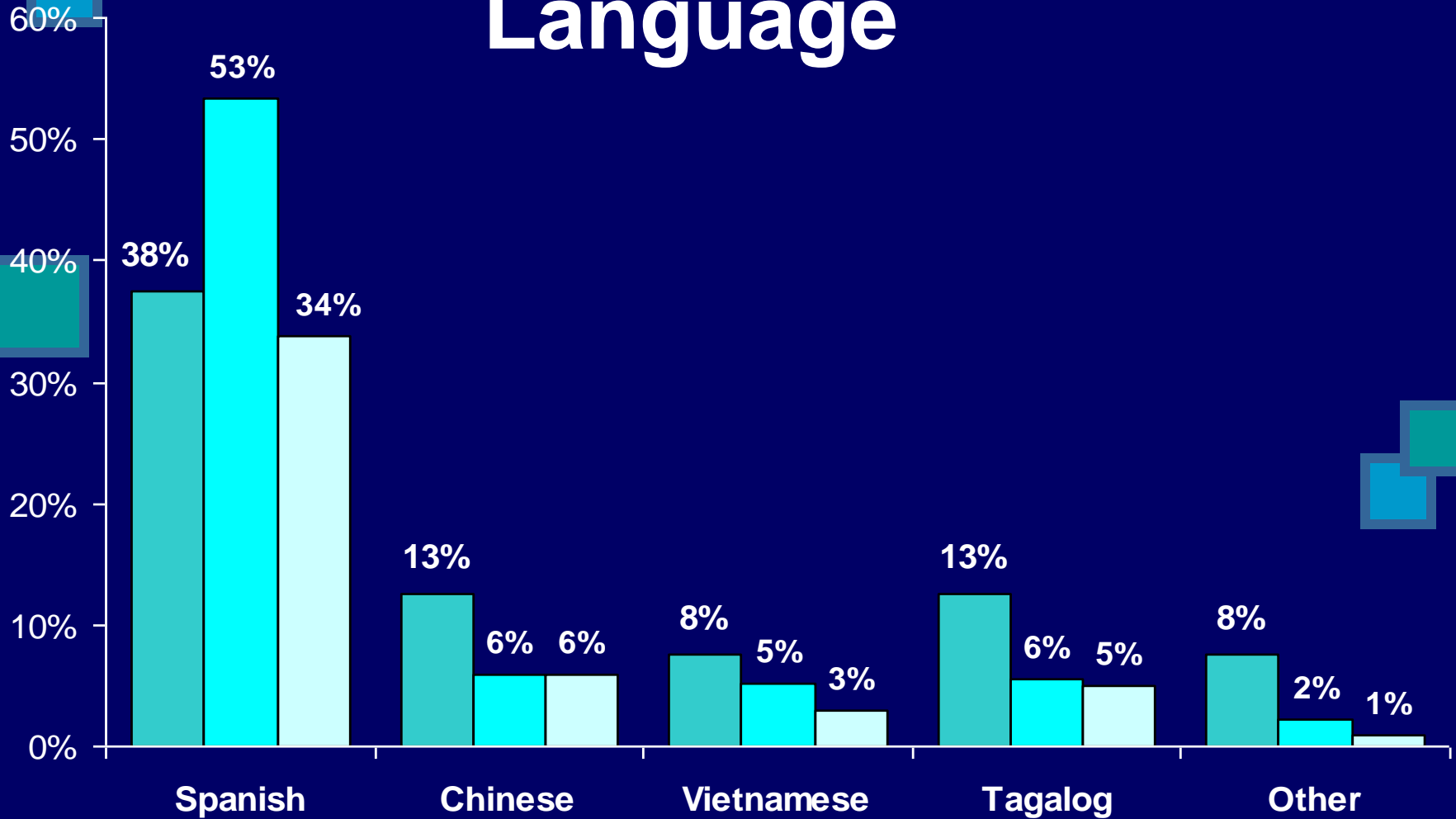




Language Concordance

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- Patients
 - English as a second language: 49%
 - Limited English proficiency: 24%
 - Practices
 - Physician can translate for patients: 73%
 - Staff can translate for patients: 92%
 - Translation services available, but generally not needed
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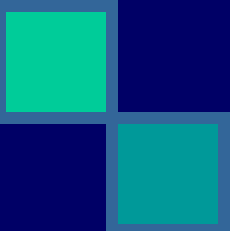

Language

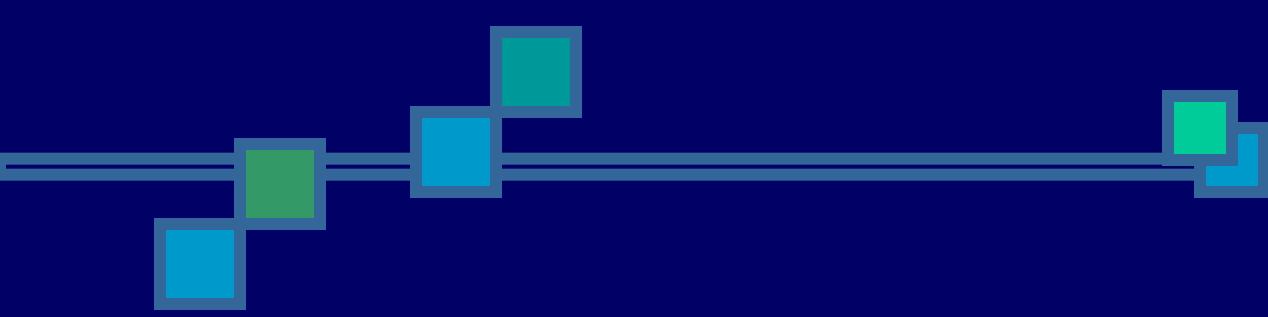



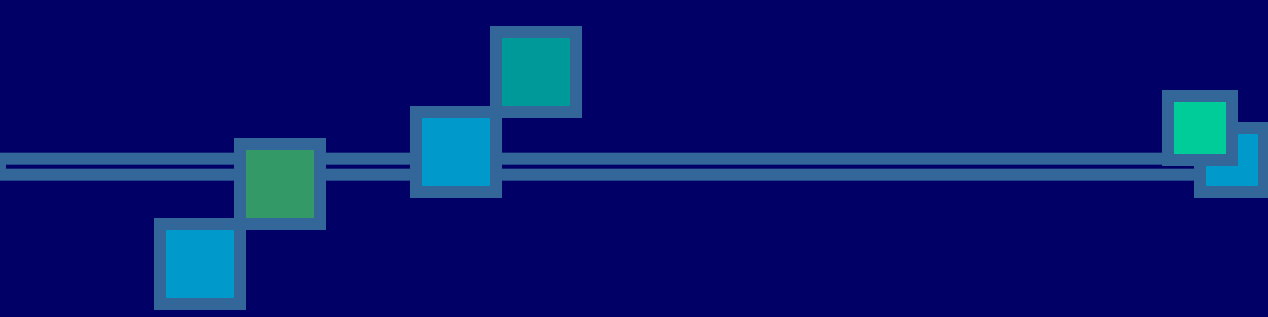
■ Physicians ■ Staff ■ Patients




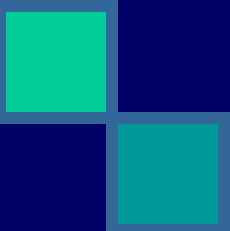
Access - Selecting a Location

- Convenience, practical reasons
 - Available office space
 - Transportation issues
 - Access to hospital/recruited by hospital
 - Ideological reasons
 - To serve a particular community
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- *"I didn't see the large medical groups and institutions investing in the minority communities, coming into the community where people of color lived. I wanted to practice in a place where I felt I would make the most difference with individuals."*
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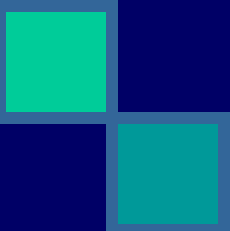



"A lot of our patients walk to the office because they don't have transportation, which might mean they don't make the appointment in the first place, or that once they are here, they've put in a lot of energy and probably should be seen that day."

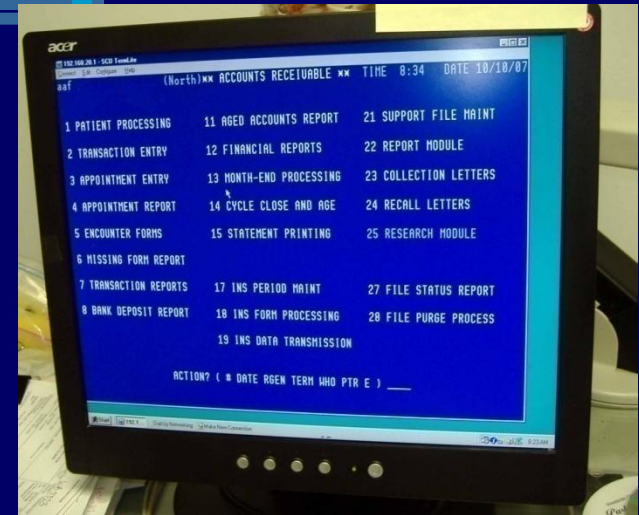




Impact of MediCal Reimbursement

- 45% Accept more MediCal patients
 - 20% Hire more/better qualified staff
 - 18% Provide better quality of care
 - 18% Keep serving MediCal patients as always
 - 15% Make infrastructure improvements
 - 10% Provide better compensation to staff
 - **10% Won't/don't take MediCal patients**
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Health Information Technology (HIT)



- 95% (38) use computers/2 "do not"*
 - Median number of computers per office: 4
 - Range: 1-20
- 68% (27) have servers
 - 12 have no server, but 2 use web-based off-site server or service

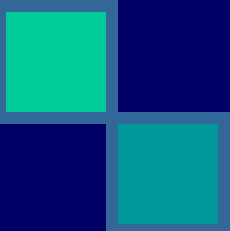



Recruiting in New Providers

- 50% feel it would be difficult to recruit new providers
 - Money/quality of life issues
 - Lack of bilingual/culturally competent providers
 - Difficulty working with other providers
 - Office is too small
 - Difficult patient population/location
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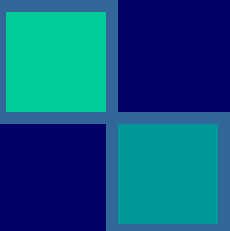



Recommendations

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- Implement an awareness campaign to describe the role played by solo/small group practice primary care physicians who serve safety net communities.
 - Address the reimbursement issues faced by solo/small group practice primary care physicians, identifying ways to increase payment for these physicians.
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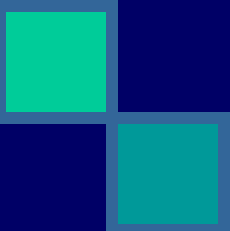


Recommendations

- 
- Strengthen the infrastructure of solo/small group practice primary care physicians to improve the quality of patient care.
 - Develop a plan to train medical office staff to strengthen their performance as a member of the care team in solo/small group primary care practice.
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Recommendations

- 
- Explore approaches to increase the number of solo/small group primary care physicians serving medically underserved communities in California.
 - Develop opportunities for partnerships at the community level that bring together solo/small group practice primary care physicians with other members of the safety net to improve access to care.
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