


Physician Focus Groups

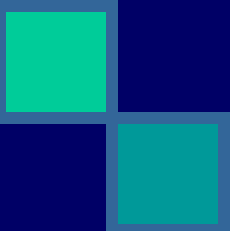


Quality Improvement in Solo and Small Group
Practice Project

This project was made possible by a
grant from The California Endowment

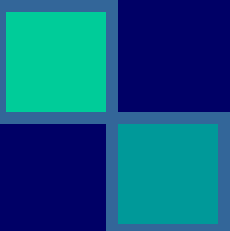



Research Conducted by
Network of Ethnic Physician Organizations
and Public Research Institute of
San Francisco State University





Purpose

- 
- Gather primary qualitative data;
 - Inform the next phase of research;
 - Introduce CMAF and NEPO;
 - Provide a forum for ethnic solo and small group practitioners to talk together
- 



Methodology






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:** African American, Hispanic, Asian & South Asian
 - **Primary care:** general practice, pediatrics, family practice, internal medicine, and obstetrics/gynecology.
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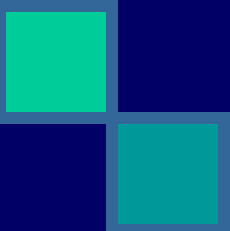



Recruitment

- **Sample:** NEPO list of ethnic primary care SSGs developed from various lists.
 - **Recruiters:** “Physician champions” contact potential participants in their regions
 - **Invitation Letters:** signed by regional ethnic physician leaders
 - **Reminders:** Numerous fax & telephone reminders
 - **Incentives:** a) a Palm Pilot with a year’s subscription to Epocrates, or b) a gift certificate of \$100.
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Focus Groups Details

- 
- **# of Participants:** 207 to date
 - **Location:** Restaurant banquet rooms in each region
 - **Duration:** 1.5-2.25 hours
 - **Size of Groups:** 5-32 participants
 - **Recording:** digital recording for full transcription
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Focus Groups by Region

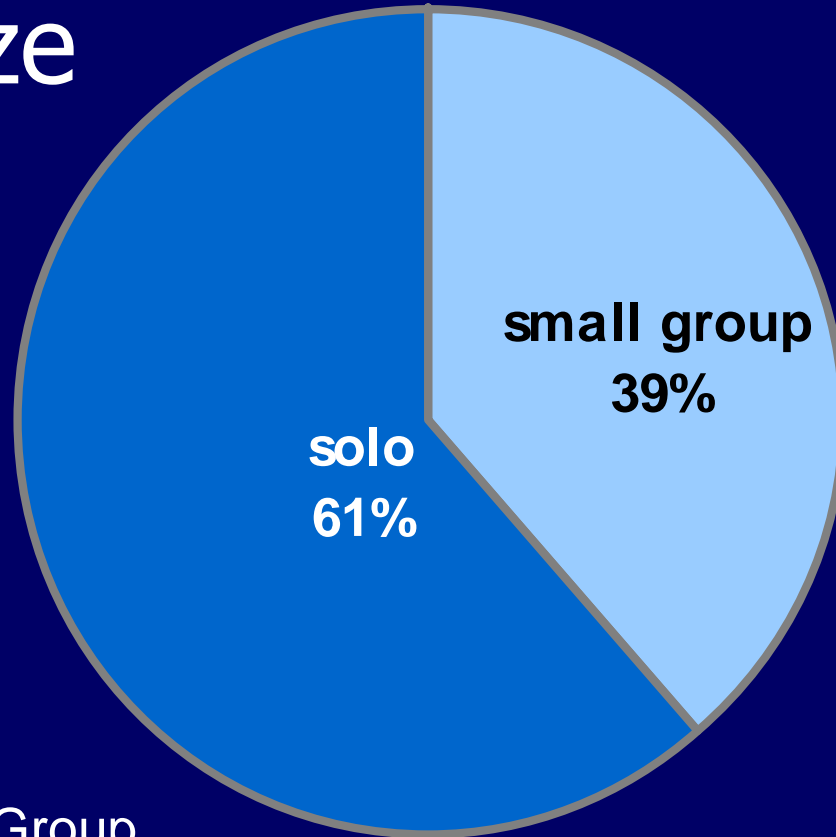
	Asian	Black	Hispanic	Multi-Ethnic
San Diego	1	1	2	0
Los Angeles	1	1	2	0
Central Valley	1	1	1	2
Bay Area	3	1	1	0
			Total	18



Focus Group Demographics

- From a short survey administered at the beginning of each focus group session.
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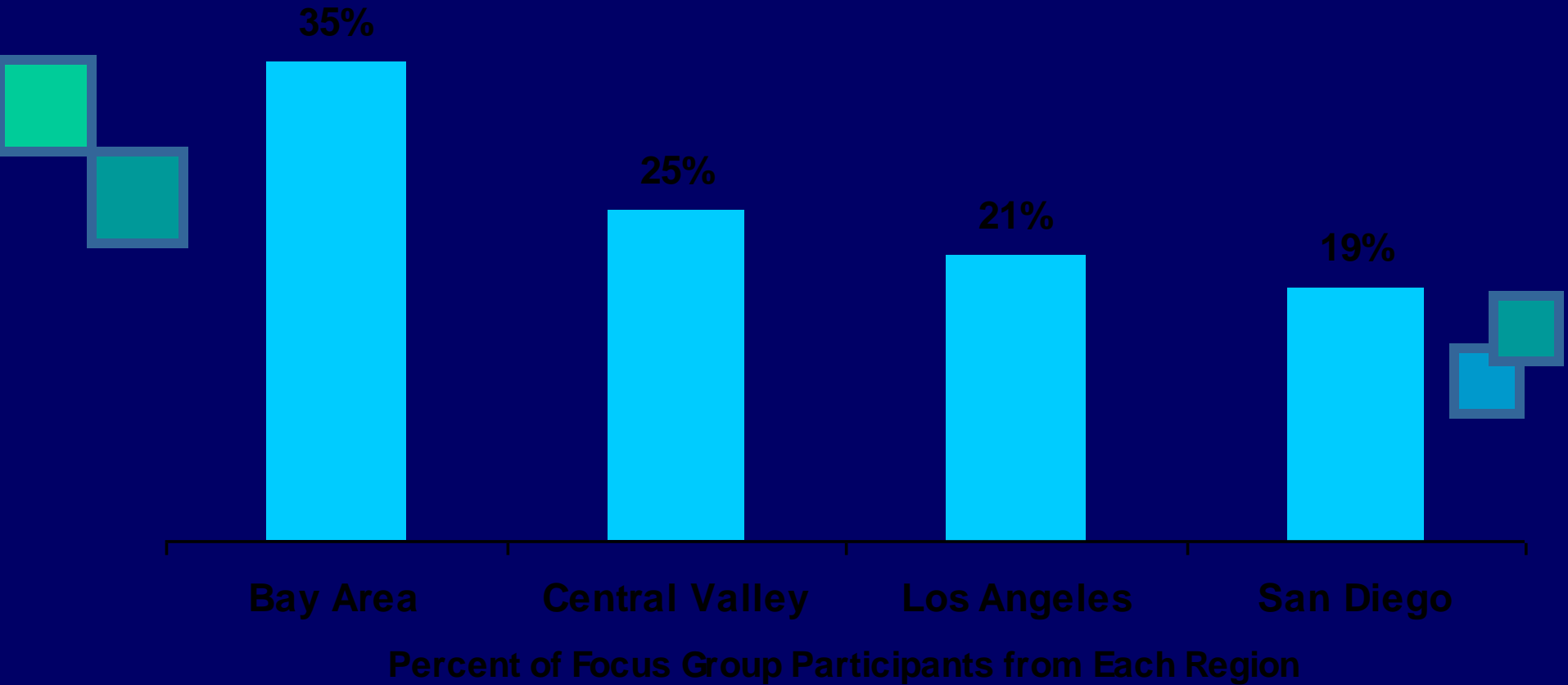
Practice Size



Percent of Focus Group
Participants in Each Category

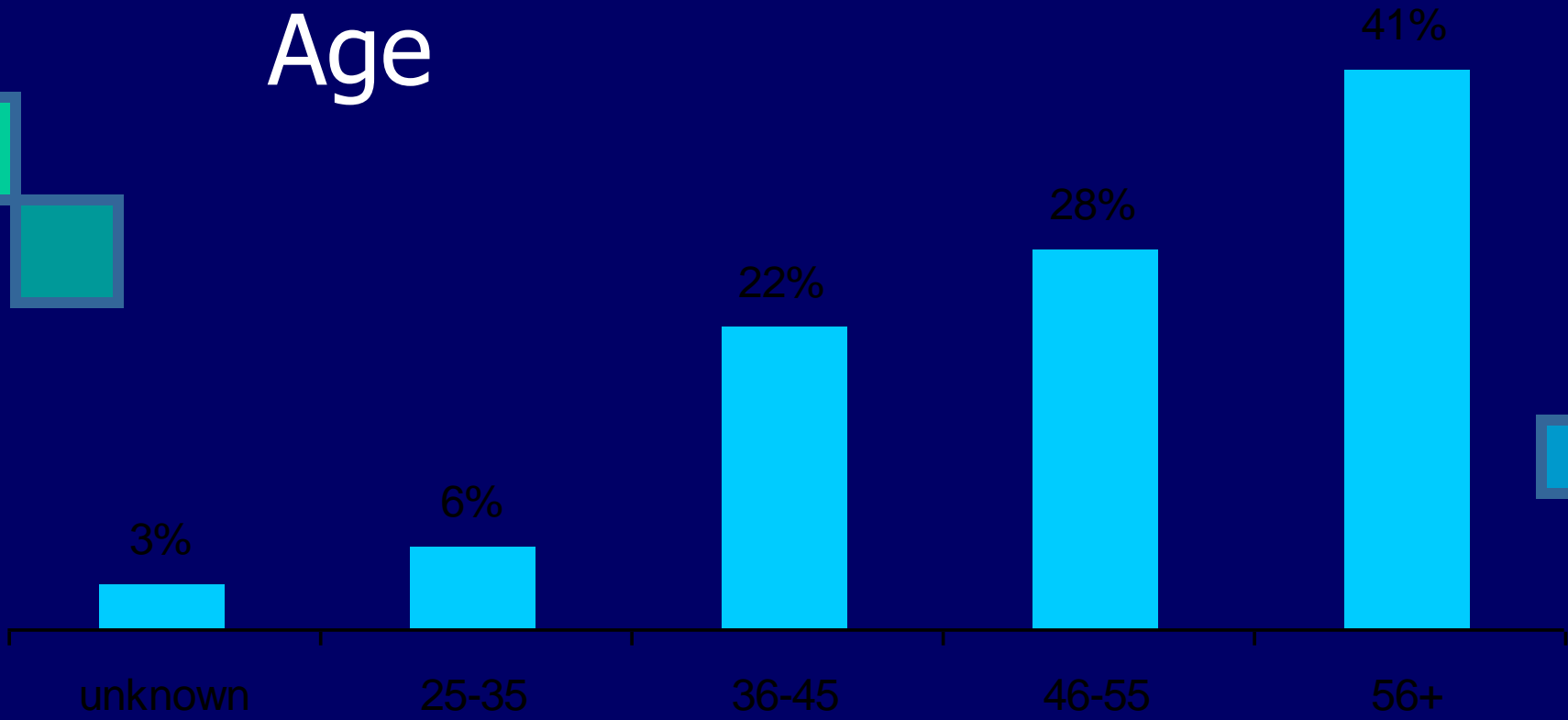
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Region



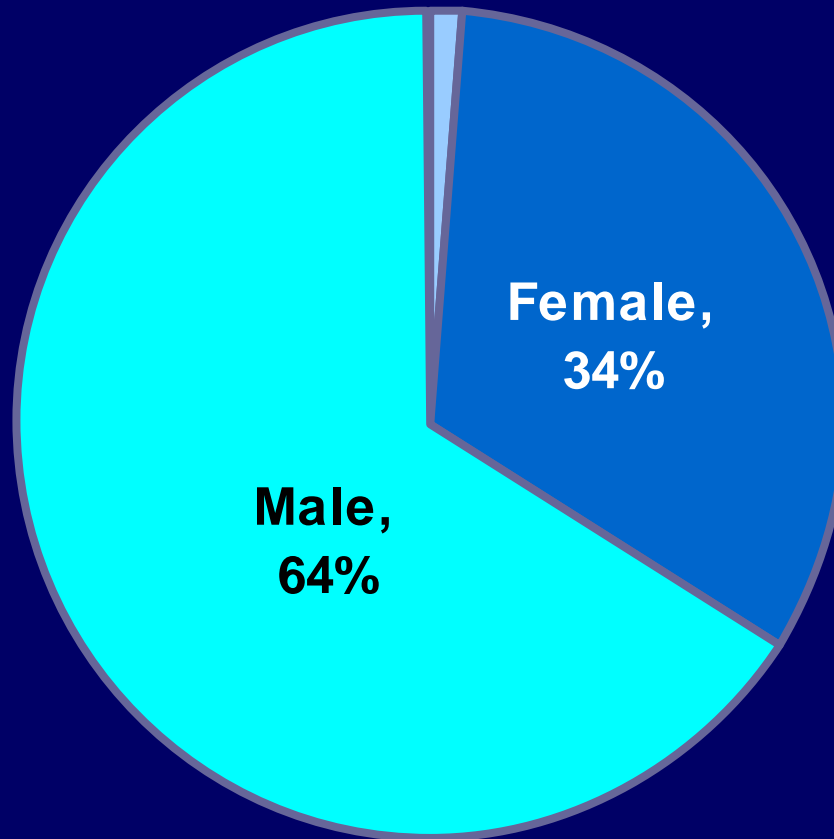
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Age



Percent of Focus Group Participants in Each Age Category

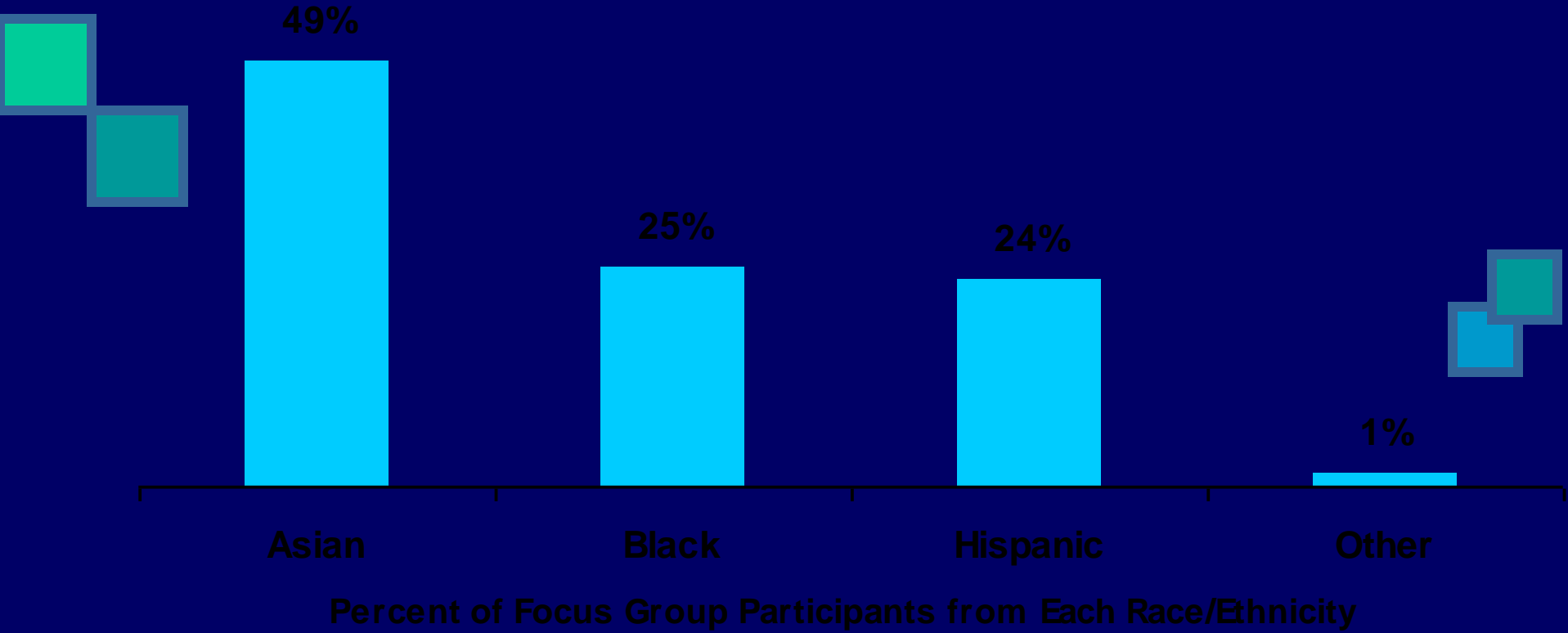
Gender



Percent of Focus Group
Participants in Each Category

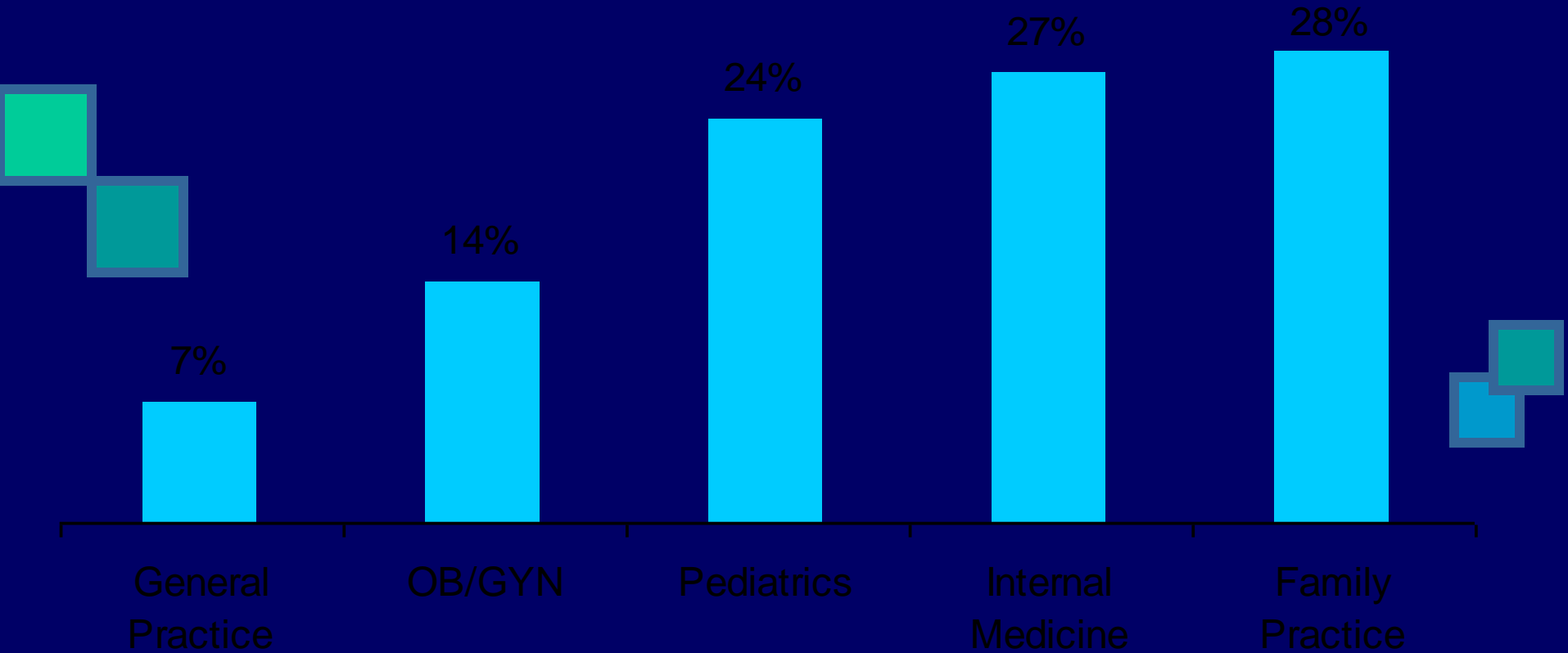
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Race/Ethnicity



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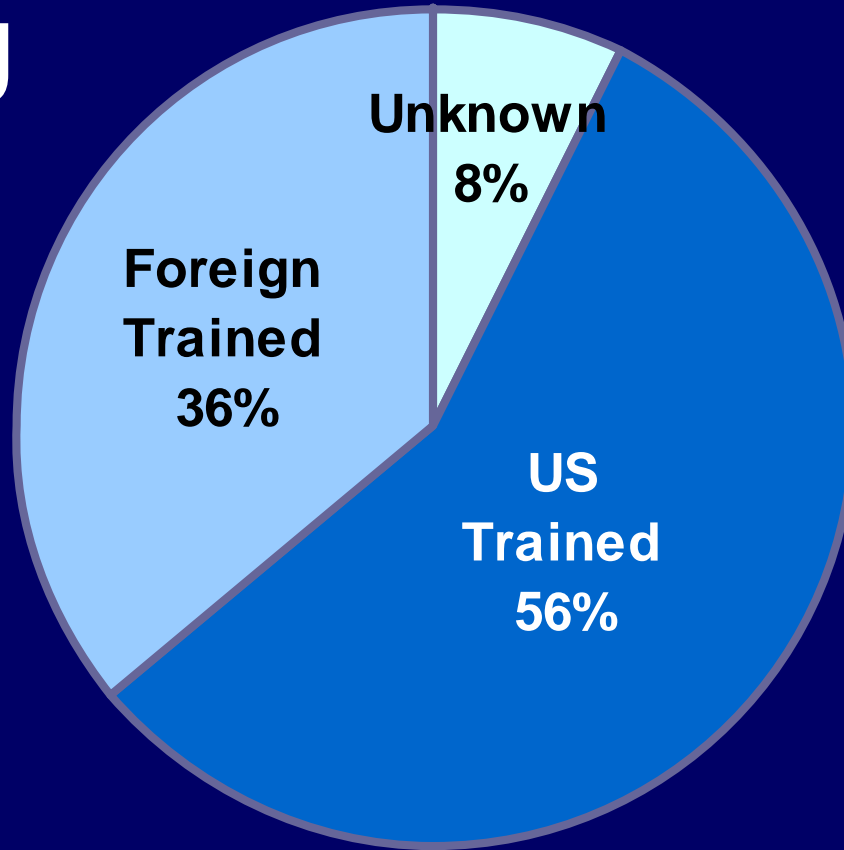
Specialty



Percent of Focus Group Participants in Each Practice Type

15

Training

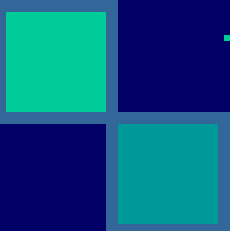


Percent of Focus Group
Participants in Each Category

16




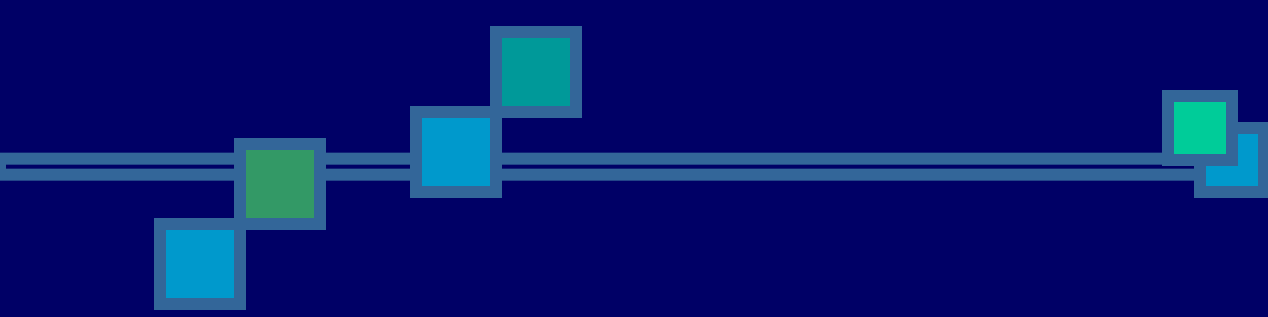

Focus Group Topics

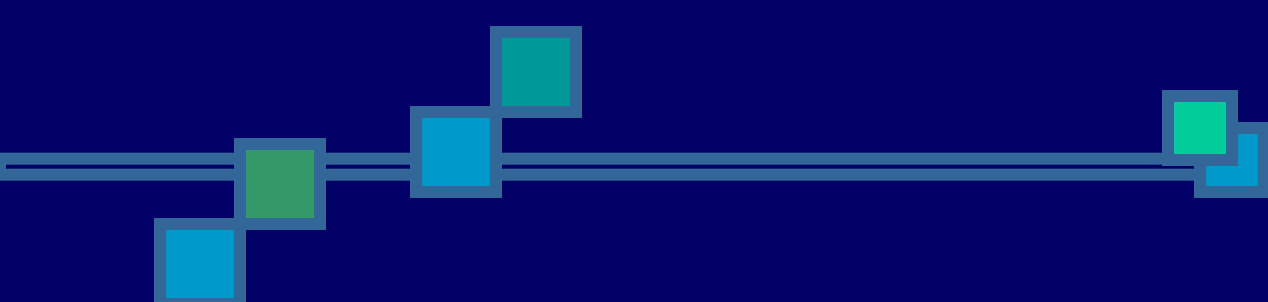
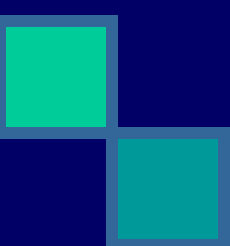

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1. Practice & Community
 2. Definitions & Measures of Quality of Care
 3. Challenges to Quality of Care
 4. Meeting the Challenges to Quality of Care
 5. Future Research
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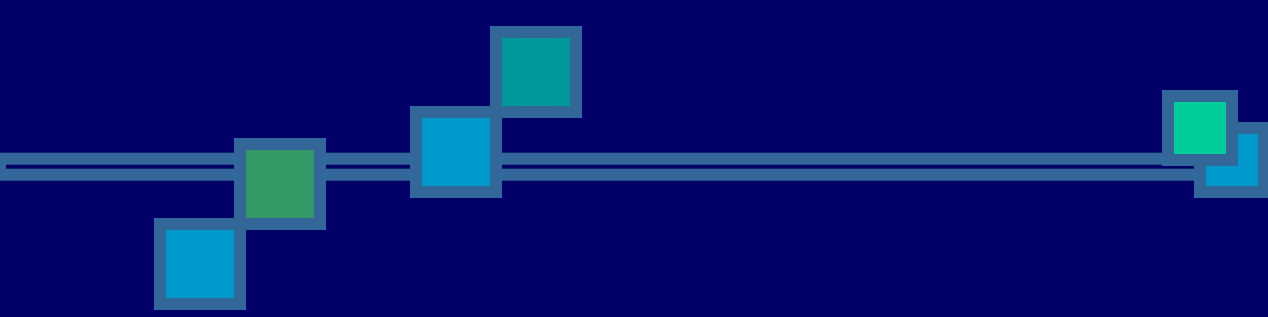
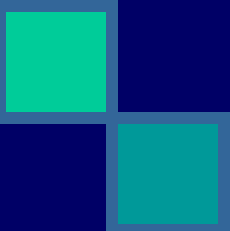



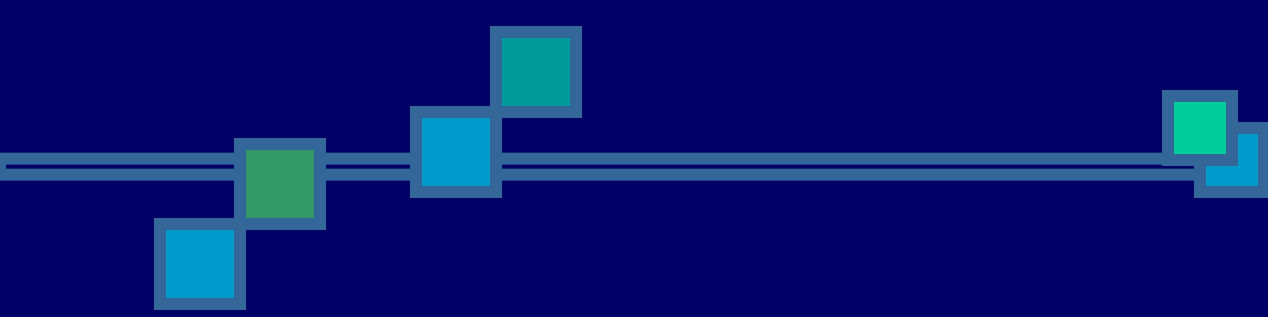

Topic 1: Practice & Community

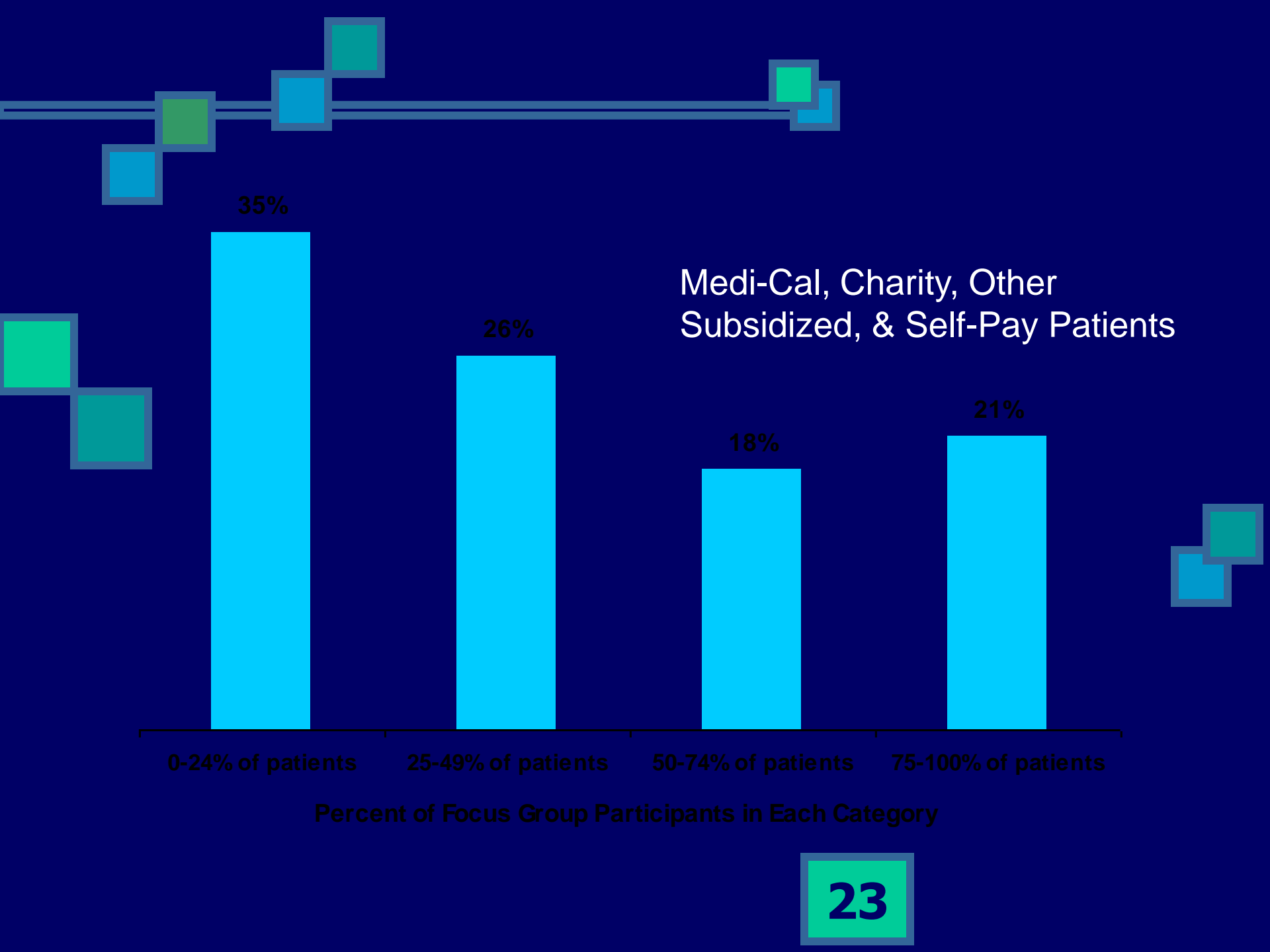
- “Tell us a little bit about your practice and the community that you serve.”
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- Many, but not all, see many patients from the same ethnic background as themselves:
 - Increasing number of Hispanic patients across the state;
 - Increasing number of Asian patients in some key areas;
 - Most diverse patient mix: Central Valley.
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- Some grew up in the communities in which they practice:
 - I actually grew up in the area...and it was always a dream to be able to go back to my community and it's been an honor...
 - It's a nice role that we have in our community that we can come back and take care of people just like us when we were growing up there.


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- Some have targeted strategic markets:
 - Let's be honest: you have to make a living. You go where nobody is home; that's where the money is ... The one thing that you have to remember is that you don't have too much competition; you are in an area in which you're providing the care.
(Physician practicing in a low-income area)
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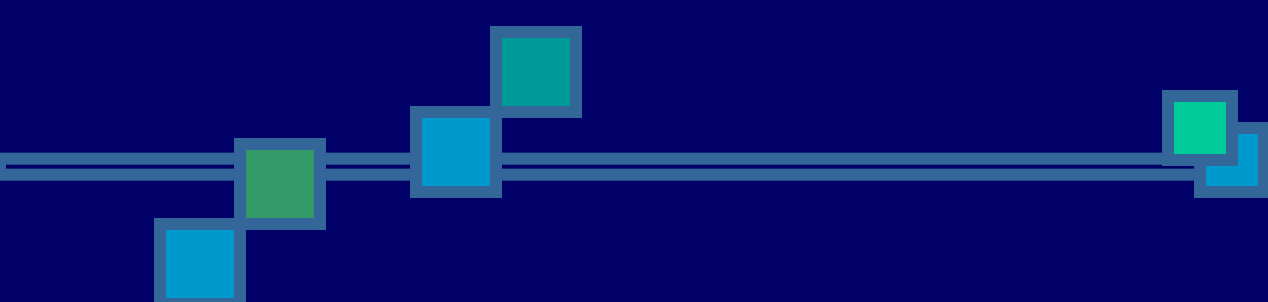

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- Many felt they had something special to offer their communities that outsiders could not offer:
 - The treatment to the (Hispanic) community and the (Hispanic) patients by other physicians is bad because of communication... You see that the patients are upset about that ... I find that they come to me because they can talk to me; they feel relaxed and the communication is there.
(Hispanic Physician)
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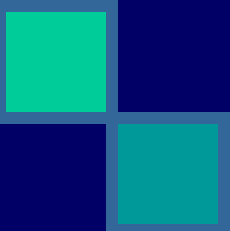

Topic 2: Defining Quality of Care

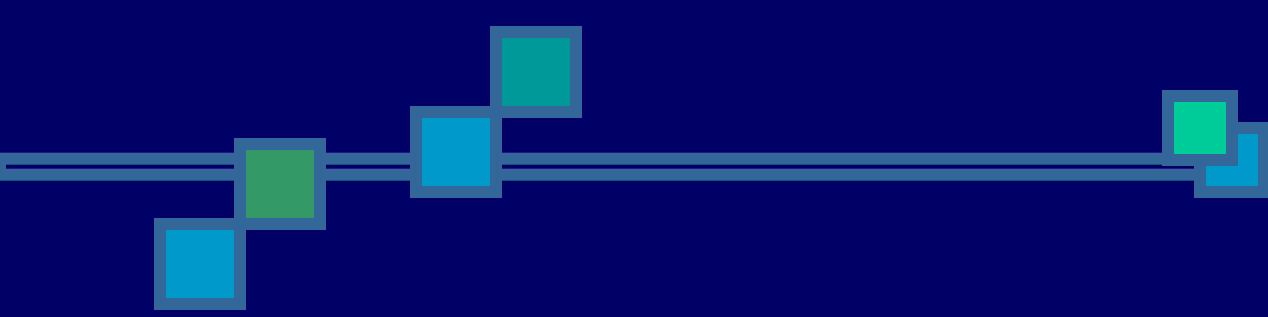
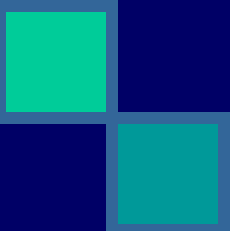

- “First, how do *you* identify and measure quality of care in a practice?”
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- Many different sources of guidelines and standards;
 - Specialty societies and academies;
 - Insurers (Medi-Cal, Medicare, IPAs and HMOs);
 - HEDIS measures (NCQA);
 - Hospitals and others.
 - Different types of measures for different aspects of Quality of Care;
 - Process
 - Outcomes
 - Patient Satisfaction
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Patient Satisfaction

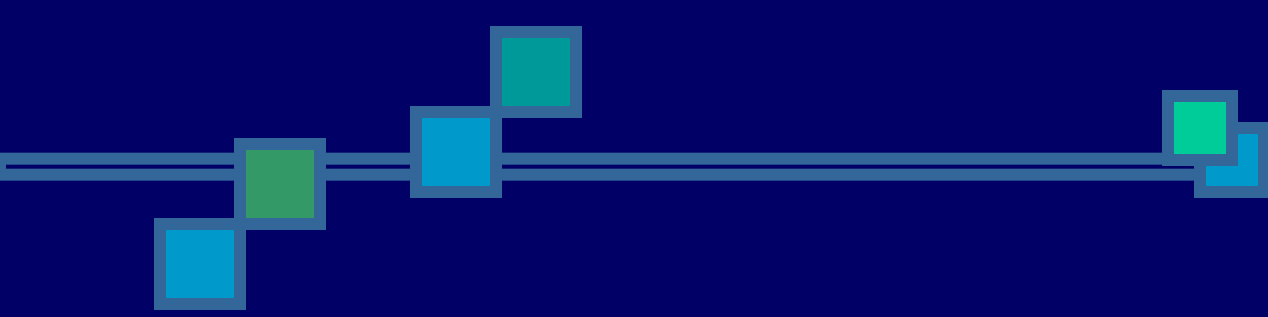
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- Measures of patient satisfaction:
 - “They keep coming back”
 - Patients refer friends and family;
 - Patients seem happier and healthier;
 - Patients don’t transfer their records or file complaints;
 - High Scores on patient satisfaction surveys.
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- “Quality of Service is not Quality of Care”
 - A lot of times people base that (patient satisfaction) on how quickly they got in and out of the office, not realizing that you took the extra time, you’re trying to do a more complete job so it takes more time to do a better job.
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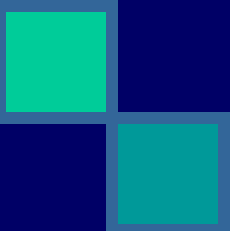



How useful are Established Guidelines in Measuring Quality of Care?

- Guidelines may impede quality of care
 - Guidelines don't take into account patient characteristics in underserved communities
 - Guidelines miss important aspects of quality of care
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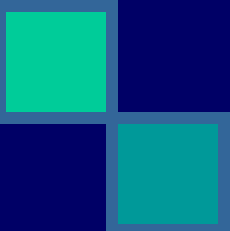




What is not included in established measures & guidelines?

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- Cultural and linguistic competency
 - Continuity of care
 - Accessibility
 - Personal attention/resource and referral
 - Equity
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Measuring Quality of Care

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- Many/most depend on external audits for aggregate measures of quality of care;
 - Practice-level measures are generally on a case-by-case basis;
 - Available technology impacts ability to measure at the practice level.
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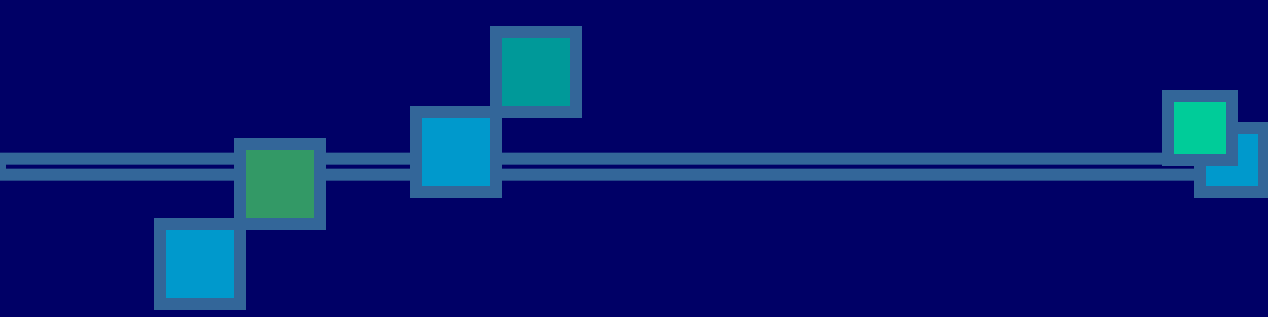

Topic 3: Challenges to Quality of Care

- “In this discussion, we’d like you to think not only about current challenges that you face, but also challenges that you see coming up in the future.”
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Inadequate Compensation

- Medi-Cal reimbursement is too low to cover costs of providing care:
 - Concerns about equity in patient care
 - Physicians (esp. specialists) refuse or limit Medi-Cal patients
 - Capitation is low;
 - Insurer underpayment is a problem;
 - Push to “see volume” negatively impacts quality of care.
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- Many physicians were concerned that inadequate compensation was keeping new ethnic physicians from starting SSG practices:
 - You could put every Hispanic doctor through medical school for the next 25 years and they'll all work for Kaiser.
(Hispanic Physician, Bay Area)
- 



Succession

- Difficulty in finding new ethnic physicians to come into solo and small group practice:
 - High medical school debt;
 - Lack of start-up capital;
 - Difficulty getting contracts;
 - Low compensation;
 - Changing attitudes about work/life balance and service to the community.
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- Impending retirements and lack of successors puts additional pressure on remaining doctors:

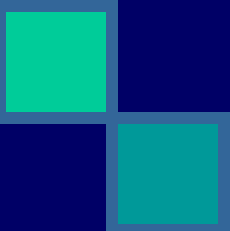

- Where are those kids going to go? Who's going to take care of them? You know? It's crazy. I can't absorb all those kids.

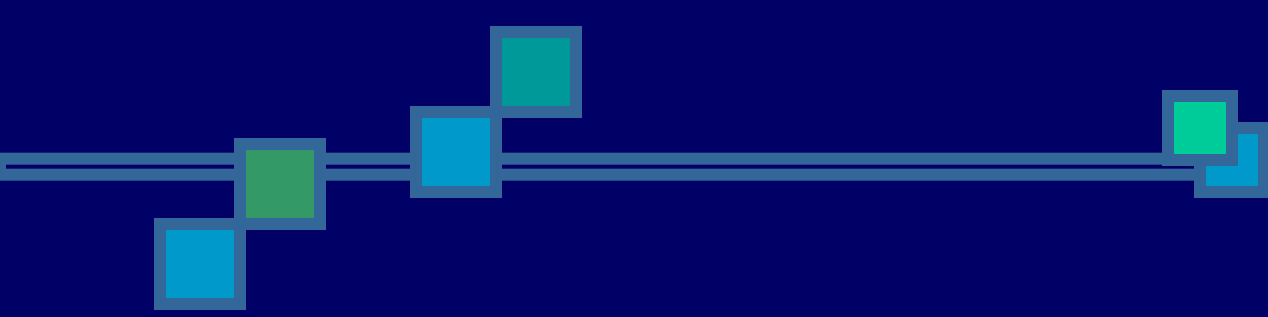
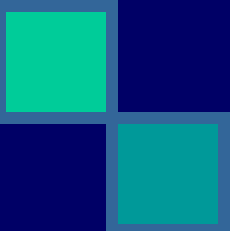

(Bay Area Pediatrician)

- No one is allowed to retire until they are DEAD! *(Central Valley Physician)*
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Administrative Burden

- 
- Rules and mandates vary across insurers and change over time.
 - Complicated and conflicting rules and mandates lead to:
 - More staff required to process paperwork;
 - Higher skilled, higher paid staff required;
 - Small mistakes result in costly delays for patients and physicians.
- 

- 
- Administrative burden also meant less time to devote to patient care:
 - The physicians are spending a lot more time in paper care than patient care. The insurance companies, they (only) care about the paperwork; how much time you spend with the patient--they never ask, or how much was not spent--that's not their concern.
- 
- 




Patient Challenges

- Patients face social & economic challenges which impact their health:
 - Patients may delay care until crisis;
 - Patients are hard to locate for follow-up and billing;
 - Patients are on and off insurance;
 - Patients can't come during office hours;
 - Safety net patients are sicker and have more complicated illnesses.
 - Patients cannot speak English.
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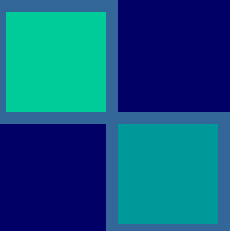



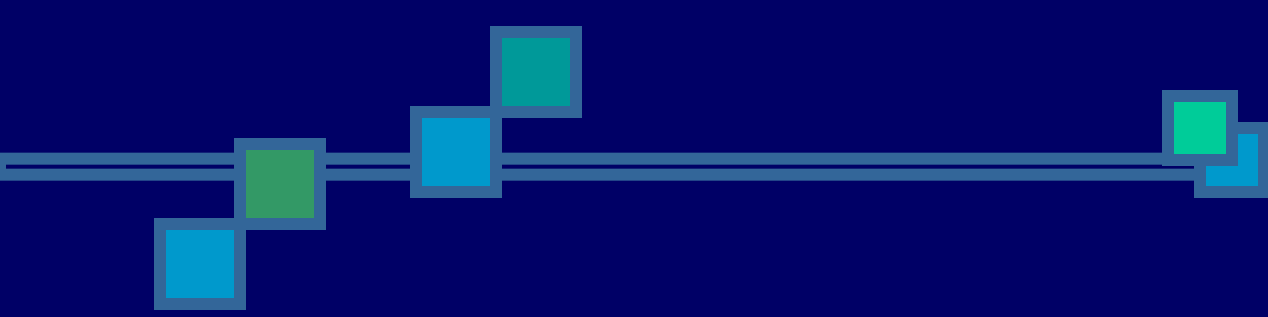
Patient Challenges are complicated:

- Number one, they are poor, they are uneducated, they are less motivated, and they lack transportation...
 - So a lot of times they can't make the office, and if you make some recommendations then they become non-compliant because of their personal problems, social problems, and then the financial problems...
- 




Staffing Challenges

- 
- HMOs and others can offer better compensation resulting in high staff turnover in SSGs;
 - Affordable staff have limited job skills and training;
 - Truly bilingual staff are vital and hard to find;
 - Cultural differences between doctors and staff may introduce stress into the office.
 - Gender differences may also play a role.
- 

- 
- Physicians also found that staff sometimes have “significant life issues” that cause absenteeism:


If one thing goes wrong, it’s going to snowball throughout their life and their support system....

In the Bay Area it’s a particular challenge in that it’s so expensive to stay here that if one thing in their life changes they don’t have the resources to deal with that. (*African American Physician*)






Topic 4: Meeting the Challenges

- “Now we would like your ideas on how to meet the challenges that we have just discussed.”
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Practice Level Solutions

- Increase Access
 - Improve Patient Education
 - Improve Language Access
 - Provide Resource & Referral
 - Improve staffing conditions
 - Enhance IT resources
 - Adjust Payer Mix
 - Share facilities
 - Hire family
 - Cut staffing or staff compensation
 - See volume
 - Find other sources of income
 - Target strategic markets
- 




- Increase Access:



We are saving them (insurers) an enormous amount of money staying there until 6:30 at night, seeing (sick) kids... (*African American Physician*)


The reason we open on Saturday is because we're trying to help our population. And if some of us, or most of us, decide to close on Saturday, then the patient... where will the patient go? They will go into an emergency room. ...if the patient ends up in the emergency room, the government has to pay more. (*Vietnamese Physician*)





- Improve Language Access

If we provide two bilingual / bicultural doctors, Spanish speaking doctors in a Spanish speaking community, we're providing greater access than a clinic that doesn't have a Spanish speaking doctors. It is not quantified but it's real. (*Hispanic Physician*)



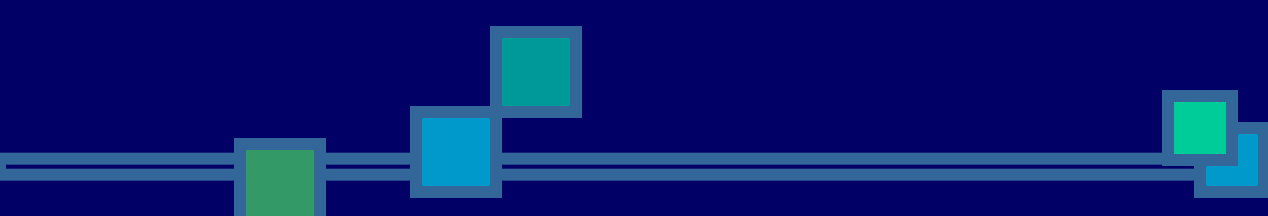
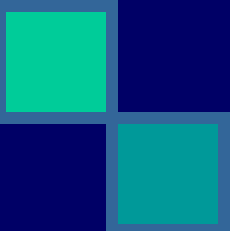



- Hire Family:

So if you have somebody who is available, who's not otherwise employed, and is somehow able to help, you can throw them into the breach to try to chip in and to keep your overhead down...

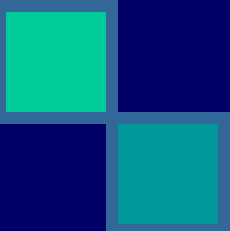

(My wife/office manager) is a CPA, so all of that helps because things are not outsourced and therefore it keeps the overhead low.

(Chinese American Physician)

- 
- Accept Cash-Pay or Out-of-Network Patients:
 - The Hispanic population is young, working, healthy, and able to pay... That's obviously a very active market that I think a lot of Latino physicians and a lot of Latino businesses count on and can actually thrive on. I hate to say it that way; that's the way we make ends meet is through the cash market.
 - (*Hispanic Physician*)
- 
- 



- Policy Level Solutions

- 
- Improve reimbursement rates
 - Subsidize & Standardize EMRs
 - Refocus Performance Incentives
 - Require all specialists to take a certain proportion of Medi-Cal patients
 - Expand Use of 95-210 Rural Health Clinic Designation
 - Simplify & standardize paperwork across insurers
 - Increase access to resources offered by/for FQHCs without losing patients
 - Gain recognition as Safety Net Providers
- 




Community Resources for Patients



Current Resources

- Community Health Clinics & other low-cost and free clinics;
- County Public Health resources
- Local Hospitals
- Patient Assistance Programs
- Transportation Services

Suggested Resources

- Behavioral and Psychiatric Services for Patients
 - Patient Education Resources
 - Dietician and nutritionist services especially
 - Media for public health education
 - Patient education materials in appropriate languages
 - Ability to offer patient education in-house
 - Specialist Referrals
- 




Community Resources for Physicians



■ Suggested Resources

- Recruitment and Retention Resources
- Resources for Start-Ups
- Small Business Assistance for SSGs
- Patient Assistance Program Clearinghouse
- Training programs for office staff
- Technical Assistance from Hospitals

■ Current Resources

- Student Interns/Externs
 - Ethnic Physician Organizations
 - Enterprise Zone Tax Credits
 - Grants from Hospitals
 - Informal Networks
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Differences by Race/Ethnicity



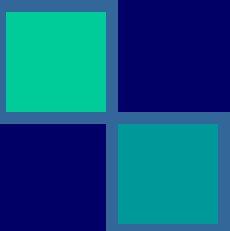



African-American Doctors

- More Medi-Cal and Charity patients on average than other doctors;
 - Most concern about succession ;
 - Most likely to cite EPO membership (72% vs. 37%);
 - More likely to be in small group rather than solo practice (49% vs. 36%);
 - English first language of most, but many know at least some Spanish.
- 




Asian Doctors

- 
- Very ethnically diverse group;
 - More than 1/2 foreign-trained (55%);
 - Less likely to have grown up in the neighborhood they serve.
 - Generally bilingual or multilingual.
 - More mention employing family members in the office (21% +);
 - Most likely to belong to IPA (80% vs. 65%).
- 



Hispanic Doctors

- Younger on average;
 - 1/4 foreign-trained (27%);
 - Generally bilingual.
 - Nearly twice as many cash-pay patients on average;
 - Least likely to cite EPO membership (23%).
 - However, repeatedly mention networking with other Hispanic doctors for support and resources.
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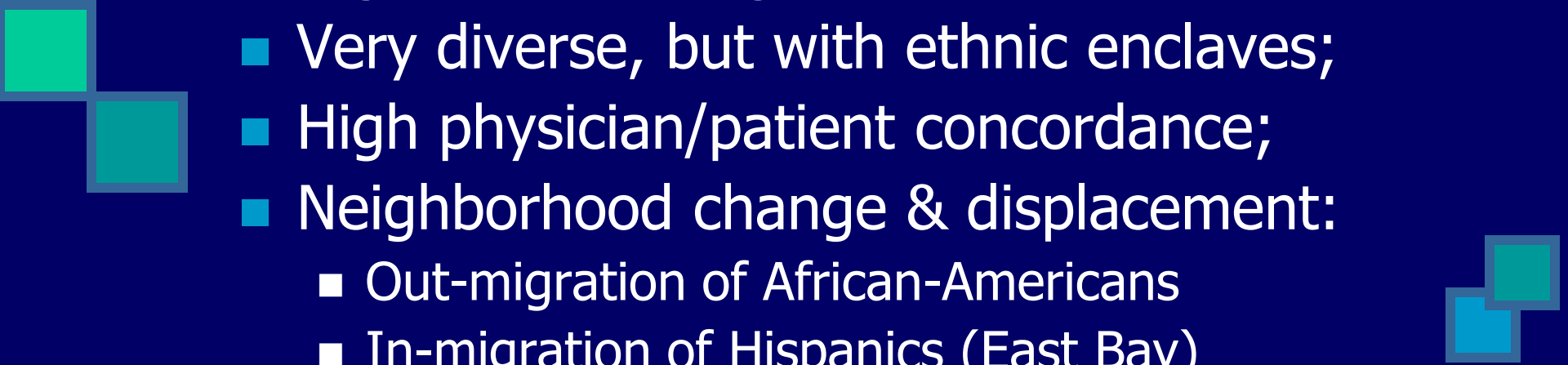


Differences by Region






Bay Area

- High cost of living;
 - Very diverse, but with ethnic enclaves;
 - High physician/patient concordance;
 - Neighborhood change & displacement:
 - Out-migration of African-Americans
 - In-migration of Hispanics (East Bay)
 - In-migration of Chinese (San Francisco)
 - Asian physicians cite strong affiliation with EPOs; Latino and African-American physicians cite few available community resources.
- 




Central Valley

- Very diverse patient mix;
 - Less physician/patient concordance;
 - Very low reimbursement rates;
 - Shortage of primary care physicians;
 - Migrant worker & refugee communities;
 - Major transportation problems;
 - Not dominated by HMOs.
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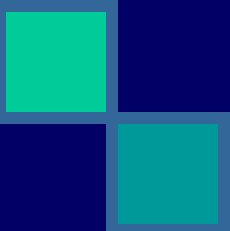



Los Angeles

- Diverse patient mix, increasingly Hispanic;
 - Physicians and/or staff need to speak Spanish;
 - More concern about crime & personal safety;
 - Participants identify few community resources:
 - More reference to (impacted) County resources
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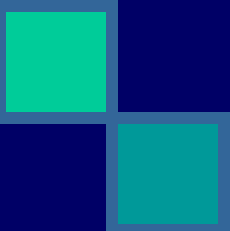


San Diego

- 
- High cost of living;
 - Very low reimbursement rates;
 - Close to the border/mobile population;
 - No county hospital.
 - Unusual health care environment (high HMO market penetration, competition)
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"We are the Safety Net"



Come on down to my clinic, you will see a single mom ... dragging her kids and they will not be able to go downtown to the hospital on the bus with 5 kids--1 on her shoulder, 2 in the stroller, some with runny noses.

We are the Safety Net; we catch them so they do not have to go on the bus with 2 in the stroller, 1 on the shoulder and all that... we provide the children with preventive care ...so they don't go to the hospital. (*Asian Physician, San Diego*)

