ASIAN AMERICAN PHYSICIANS IN SOLO AND SMALL GROUP PRIMARY CARE PRACTICES:

ESSENTIAL HEALTH CARE PROVIDERS FOR OUR COMMUNITIES

November 2012

By

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with assistance from

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Quality Improvement in Solo and Small Group Practice

Strengthening the Private Practice Safety-Net

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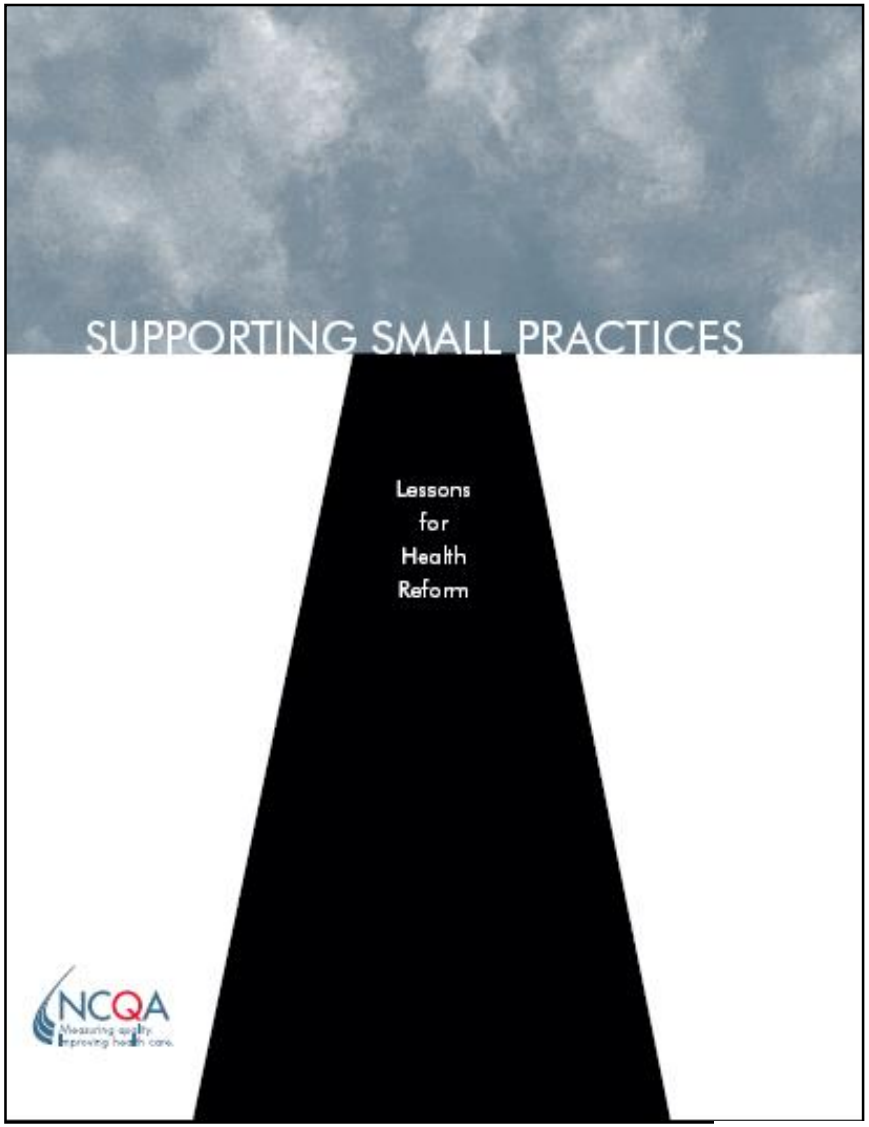

http://www.ncqa.org/Portals/0/HEDISQM/CLAS/Briefing/Small_Practices_Report.pdf

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Project Background

- **Funded by U.S. Department of Health and Human Services Office of Minority Health**

- **Collect data from Asian American, Native Hawaiian, and Pacific Islander primary care physicians in solo and small group practices serving Asian American, Native Hawaiian, and Pacific Islander patients**

- **Data collected November 2011 – May 2012**

- **Report issued November 2012**

http://s3.amazonaws.com/NCAPIPportalDocfiles/NCAPIP_Report_Asian_Primary_Care_Practices.pdf

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Primary Care Practices in the U.S.

- 84% primary care visits are at office-based practices
- 74% all ambulatory care visits are at practices with 5 or fewer physicians (31% are at solo practitioners)
- 70% internal medicine practices, 69% general/family practices, 52% pediatric practices are solo practitioners

Hing E, Uddin S. Visits to Primary Care Delivery Sites – United States, 2008. *National Center for Health Statistics Data Brief No. 46* (2010)

Hsiao C-J, Cherry DK, Beatty PC, Rechsteiner EA, National Ambulatory Medical Care Survey: 2007 Summary. *National Health Statistics Reports No. 27* (2010)

Hing E, Burt CW. Office-based Medical Practices: Methods and Estimates from the National Ambulatory Medical Care Survey. *Advance Data From Vital and Health Statistics No. 383* (2007)

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Primary Care Practices in the U.S.

- 17% primary care visits are paid by Medicare, 13% by Medicaid/Children's Health Insurance Program, 4% uninsured

- Half of all office-based practices have implemented an electronic health record (EHR) but only 37% of solo/2-physician practices have

- Over 80% of office-based practices could qualify for HITECH Act EHR incentive payments

Hing E, Uddin S. Visits to Primary Care Delivery Sites – United States, 2008. *National Center for Health Statistics Data Brief No. 46* (2010)

Decker SL, Jamoom EW, Sisk JE. Physicians in nonprimary care and small practices and those age 55 and older lag in adopting electronic health record systems. *Health Aff.* 2012;31(5):1-6

Bruen BK, Ku L, Burke MF, Buntin MB. More than four in five office-based physicians could qualify for federal electronic health record incentives. *Health Aff.* 2011; 30(3):472-479

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Data Collection

- Pre-focus group survey (44 primary care physicians) (responses online, by fax, by hand)

- 7 focus groups (54 primary care physicians + 19 other physicians in Honolulu, San Francisco, San Jose, Chicago, Dallas, Houston, New York

- Among primary care physicians, 38% solo practitioners, 63% in practices of 5 or fewer physicians)

- Post-focus group evaluations (62 responses, 85% response rate)

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Participating Physician Demographics

- Focus group primary care physicians practiced internal medicine, family medicine, pediatrics

- Focus group primary care participants were Chinese, Vietnamese, Filipino, Japanese, Indian, Burmese, White

- 66% of focus group primary care participants were men, 34% women

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Participating Physician Demographics

- Median years in practice = 22 years
- 66% speak languages in addition to English when seeing patients
- 3/4 have clinical staff who speak languages in addition to English
- 3/4 have administrative staff who speak languages in addition to English

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Focus Group Discussions

“Becoming a primary care provider is a calling, it’s not for the money”

“The reason I became a physician was to help others”

“It’s a calling, we care deeply about our patients”

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Focus Group Discussions

“I feel that I am just a referral doctor. How much I am paid depends more on the number of patients I see, not the care I provide”

“We try to run faster on a hamster wheel, and will just deliver hamster wheel care until we fall off”

“We will burn out, and no one will be happy, neither physicians or our patients”

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Payers

- 88% have uninsured self-pay patients
- 64% serve patients without charge/on charity basis (average = 3.6% of patients)
- 69% have Medicaid/Children's Health Insurance Program patients
- 76% have Medicare patients

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Focus Group Discussions

Asian American, Native Hawaiian, and Pacific Islander patients face language and literacy barriers

Translations of forms and patient education materials "often bad, misleading, inaccurate"

There is "cultural ignorance and insensitivity" in health care

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Focus Group Discussions

Asian American, Native Hawaiian, and Pacific Islander patients "don't speak up", "just put up with poor care"

Asian American, Native Hawaiian, and Pacific Islander patients "need to be better educated about their own health"

"My patients are very demanding, needy, and lack social support"

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Electronic Health Records (EHR)

- 88% currently use EHR
- 59% implemented EHR in 2010 or earlier
- 95% have heard of HITECH Act EHR incentive payments
- 75% intend to apply for HITECH Act EHR incentive payments

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Electronic Health Records (EHR)

- Most frequent sources of information about HITECH Act are local medical societies, Centers for Medicare & Medicaid Services (CMS), other physicians

- 32% had signed participation agreement with Regional Extension Center

- 25% who had not yet signed participation agreement with Regional Extension Center intended to do so

- 38% knew other physicians who had already received their HITECH Act EHR incentive payments

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Electronic Health Records (EHR)

- Most frequent uses of EHR are to document demographic data and vital signs, track lab results, prepare office visit summaries, electronic prescribing

- Least frequent uses of EHR are electronic reminders to patients, receiving hospital discharge instructions electronically

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Focus Group Discussions

“Eventually everyone will have to implement an EMR”*

“EMRs are still the future of health care”

“EMRs are the way to go in the future, it’s a must”

***EMR vs. EHR**

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Focus Group Discussions

Physicians will retire rather than implementing an EMR

“EMRs are the worst thing to happen to health care”

EMR implementation is “like putting a rock in your mouth, you can grind it down, but it’s not really what you want to do”

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Quality Improvement

- 54% receive their own performance data on quality measures (most frequently from health plans, medical groups/independent practice associations)

- 41% have received training on quality improvement (through CME, conferences, quality improvement initiatives)

- 45% have received technical assistance on quality improvement (most frequently from health plans)

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Focus Group Discussions

Medical homes "are what everyone tries to do in primary care"

"I'm already a medical home, sending notes and following up with specialists, explaining lab results to my patients"

Medical homes are "what we have always done"

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Focus Group Discussions

Concept of medical homes good but "won't work financially, it can only work in a large medical group"

Medical homes "take away all the clinical decisions away from us"

"Maybe patients don't want a medical home, they should be able to pick and choose their providers"

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Focus Group Discussions

The concept of an accountable care organization (ACO) "scares me"

Unfair to be benchmarked against own past costs in accountable care organizations because average costs already low

"I am very disappointed to hear about ACOs and feel that if you join an ACO, you will lose control"

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Focus Group Discussions

Our patients don't know about the health care reform law, don't realize what changes will happen

Asian language media is covering the health care reform law and its implementation

Concerns about misinformation and deliberate attempts to deceive consumers through unscrupulous marketing

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Focus Group Discussions

“Our health care system is far sicker than our patients”

“The whole health system is broken, not just for Asian Americans”

“This is the time for health care transformation, what is our legacy?”

“There is no turning back, we are going forward with something different, we can’t be nostalgic”

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Focus Group Discussions

“Every policymaker should spend a morning at a solo or small group practice to understand challenges in delivering health care today”

“We need to be at the table, to have a clear voice, not just grumble”

95% participants would participate in future surveys or focus groups

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Limitations

- Challenges in recruitment (need prior relationships and personal, repeated contacts)
- No Native Hawaiian or Pacific Islander physician participants (but some participants serve Native Hawaiian and Pacific Islander patients)
- Convenience sampling, not generalizable
- Technical issues in matching survey responses (didn't ask for names) with focus group participants

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Recommendations

- **Recognize HITECH Act Medicaid-eligible providers* as "essential community providers" for "qualified health plans" in health insurance exchanges**

- **Conduct culturally and linguistically appropriate outreach to impacted communities about health reform**

- **Engage ethnic language media in educating community members about health care reform**

***<30% Medicaid patients, 20% for pediatricians**

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Recommendations

- Monitor CMS and state implementation of the Medicaid EHR incentive program to maximize participation by solo and small group practice primary care physicians

- Develop and make available standardized, open-source, interoperable EHR solutions

- Support customization of EHR templates

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Recommendations

- Impose more aggressive requirements for health information exchange

- Develop and leverage culturally and linguistically appropriate patient-facing functions of EHRs to improve communication and engagement with patients, families, and caregivers

- Educate and engage primary care providers about the benefits of medical homes

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Recommendations

- **Provide technical assistance to solo and small group primary care practices on health care quality improvement using Regional Extension Centers, Primary Care Extension Centers, Community-Based Collaborative Care Networks, and Community Health Teams**

- **Fund independent practice associations, minority physician organizations, and other physician-support entities to provide technical assistance to solo and small group primary care practices on health care quality improvement**

- **Support training on quality improvement for clinical and administrative staff in solo and small group primary care physician practices**

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Dissemination

- Conducted briefing for Office of Minority Health and Office of National Coordinator for Health IT

- Conducted dissemination meetings in Honolulu, San Francisco, and Washington, DC

- Some recommendations have been adopted

- Some additional relevant data and publications on solo and small group physician practices

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Covered California Adopts NCAPIP Recommendation to Include Additional Medicaid Providers as Essential Community Providers

On June 11, 2012, the National Council of Asian Pacific Islander Physicians (NCAPIP) made a written recommendation to Covered California that the definition of essential community providers required to be included in the provider networks of qualified health plans contracted to offer health insurance through the state marketplace be broadened to include Health Information Technology for Economic and Clinical Health (HITECH) Act-defined Medicaid eligible providers, defined as providers with at least 30% Medicaid patients (20% for pediatricians).

On July 16, the Covered California staff proposed a broader definition of essential community providers to include "other providers that had demonstrated service to Medi-Cal, low income, and medically underserved populations", including Medi-Cal providers who had been approved for HITECH Act electronic health record incentive program payments.[1]

At the August 23 meeting of the Covered California board, the Covered California staff finalized the adoption of a broader definition of essential community providers for the 2014 plan year, which includes "all providers with approved applications for the HI-TECH Medi-Cal Electronic Health Record Incentive Program" (page 135).[2]

The CMS Innovation Center

The Center for Medicare & Medicaid Innovation (the Innovation Center) with CMS supports the development and testing of innovative health care payment and service delivery models.

Transforming Clinical Practice Initiative

Practice Transformation Networks Support and Alignment Networks

Awards to be announced summer 2015

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- **In 2012, 69% primary care physicians were using an EHR**

- **But only half of primary care physicians in solo practice were using EHRs, compared to 90% in practices with 20 or more physicians**

- **Only 33% primary care physicians with EHRs are exchanging clinical summaries with other clinicians; only one-third are providing electronic access for their patients**

Audet A-M J, Squires D, Doty MM,. Where are we on the diffusion curve? Trends and drivers of primary care physicians' use of health information technology. *Health Serv Research* (2014);49(1 Pt. 2):347-360

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- **In 2013, 78% office-based physicians were using an EHR**

- **69% are participating or intend to participate in meaningful use incentive program**

- **While 83% with EHRs are recording patient demographics, only 57% are providing patient reminders**

Hsiao C-J, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001-2013. Data Brief No. 143, National Center for Health Statistics (2014)

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By Andrew M. Ryan, Tara F. Bishop, Sarah Shih, and Lawrence P. Casalino

Small Physician Practices In New York Needed Sustained Help To Realize Gains In Quality From Use Of Electronic Health Records

ABSTRACT The 2009 American Recovery and Reinvestment Act spurred adoption of electronic health records (EHRs) in the United States, through such measures as financial incentives to providers through Medicare and Medicaid and regional extension centers, which provide ongoing technical assistance to practices. Yet the relationship between EHR adoption and quality of care remains poorly understood. We evaluated the early effects on quality of the Primary Care Information Project, which provides subsidized EHRs and technical assistance to primary care practices in underserved neighborhoods in New York City, using the regional extension center model. We found that just general participation in, or exposure to, the project was not enough to improve quality of care. It took sustained exposure on the part of these practices and technical assistance to them before they demonstrated improvement on measures of care most likely to be affected by the use of electronic health records, such as cancer screenings and care for patients with diabetes. Participating in the Primary Care Information Project for nine or more months was associated with significantly improved quality, but only for this limited group of quality measures and only for physicians receiving extensive technical assistance.

Ryan AM, Bishop TF, Shih S, Casalino LP. Small physician practices in New York needed sustained help to realize gains in quality from use of electronic health records. *Health Aff.* (2014)32(1):53-62

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By Lawrence P. Casalino, Frances M. Wu, Andrew M. Ryan, Kennon Copeland, Diane R. Rittenhouse, Patricia P. Ramsay, and Stephen M. Shortell

Independent Practice Associations And Physician-Hospital Organizations Can Improve Care Management For Smaller Practices

ABSTRACT **Pay-for-performance, public reporting, and accountable care organization programs place pressures on physicians to use health information technology and organized care management processes to improve the care they provide. But physician practices that are not large may lack the resources and size to implement such processes. We used data from a unique national survey of 1,164 practices with fewer than twenty physicians to provide the first information available on the extent to which independent practice associations (IPAs) and physician-hospital organizations (PHOs) might make it possible for these smaller practices to share resources to improve care. Nearly a quarter of the practices participated in an IPA or a PHO that accounted for a significant proportion of their patients. On average, practices participating in these organizations provided nearly three times as many care management processes for patients with chronic conditions as nonparticipating practices did (10.4 versus 3.8). Half of these processes were provided only by IPAs or PHOs. These organizations may provide a way for small and medium-size practices to systematically improve care and participate in accountable care organizations.**

Casalino LP. Independent practice associations and physician-hospital organizations can improve care management for smaller practices. *Health Aff.* (2013)32(8):1376-1382

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Support and Strategies for Change Among Small Patient-Centered Medical Home Practices

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ABSTRACT

PURPOSE We aimed to determine the motivations and barriers facing small practices that seek to adopt the patient-centered medical home (PCMH) model, as well as the type of help and strategies they use.

METHODS We surveyed lead physicians at practices with fewer than 5 physicians, stratified by state and level of National Committee for Quality Assurance PCMH recognition, using a Web-based survey with telephone, fax, and mail follow-up. The response rate was 59%, yielding a total sample of 249 practices from 23 states.

RESULTS Improving quality and patient experience were the strongest motivations for PCMH implementation; time and resources were the biggest barriers. Most practices participated in demonstration projects or received financial rewards for PCMH, and most received training or other kinds of help. Practices found training and help related to completing the PCMH application to be the most useful. Training for patients was both less common and less valued. The most commonly used strategies for practice transformation were staff training, systematizing processes of care, and quality measurement/goal setting. The least commonly endorsed strategy was involving patients in quality improvement. Practices with a higher level of PCMH recognition were more likely to have electronic health records, to report barriers, and to use measurement-based quality improvement strategies.

CONCLUSIONS To spread the adoption of the PCMH model among small practices, financial support, practical training, and other help are likely to continue to be important. Few practices involved patients in their implementation, so it would be helpful to test the impact of greater patient involvement in the PCMH.

Scholle SH, Asche SE, Morton S, Solberg LI, Tirodkar MA, Jafu CR. Support and strategies for change among small patient-centered medical home practices. *Ann Fam Med.* (2013);11(Suppl 1):S6-S13

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Follow-up Actions

- Had follow-up discussions with physicians in Honolulu (August 2014) and in San Francisco (October 2014)

- Planning additional follow-up discussions with physicians in Los Angeles, New York, and Chicago in 2015

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Questions and Discussion

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