

Realities of Medical Practices

Serving African Americans
in East Oakland

2013





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EXECUTIVE SUMMARY

1.

With the Affordable Care Act (ACA) implementation and its mandates less than a year away, healthcare policy makers, payers and providers alike are attempting to understand and prepare for its impact. While the ACA will provide healthcare coverage for millions of currently uninsured Americans, there are still many questions about where these newly covered individuals will receive their care. Concerns include a worsening shortage of new primary care providers, physicians choosing not to see low-income patients, and questions about whether, in response to the pressure of the ACA, physicians will choose to retire early or pursue other paths in medicine such as administration, research or academia. Thus, before we can begin to predict the future impact of the ACA, an assessment of current sources of care must be undertaken. Specifically, we must have a firm grasp on current points of access to culturally competent care for low-income individuals, as well as their present and future capacity.

Preparing for the impact of the ACA is of the utmost importance in low-income communities where access is already challenging, and current systems of care are already impacted.

It is likely that entities that never cared for low-income individuals will begin to compete for newly-insured patients. It is also possible that low-income patients receiving new coverage will choose to leave their current source of care. Given all of these potential shifts in the landscape, it is important that stakeholders remain focused on working to improve access to culturally competent care and improving the overall health of low-income communities, particularly those in which health statistics are the most troubling.

African Americans in East Oakland experience staggering health disparities when compared to the rest of the county, including a significantly shorter life expectancy, more mental health issues and a higher disease burden, even among children. Issues leading to these disparities are complex, but include higher incidences of poverty, violence, trauma and incarceration, as well as a lack of availability of safe spaces, fresh foods and economic opportunity. And according to an ongoing survey of primary care provider availability within the census tracts comprising East Oakland's predominant MSSA's

Given all of these potential shifts in the landscape, it is important that stakeholders remain focused on working to improve access to culturally competent care and improving the overall health of low-income communities, particularly those in which health statistics are the most troubling.

EXECUTIVE SUMMARY 1.

(Medical Service Study Areas), the ratio of low income patients to all providers who will see them (inclusive of private practice, public and other clinics, and Federally Qualified health Centers) is approximately 5500:1. This is far above the 3500:1 ratio that classifies an area as a Health Professions Shortage Area. Given the unacceptable health status of East Oakland residents, and the shortage of providers who will see them, it is critical that a comprehensive assessment of healthcare access for East Oakland residents be undertaken in order to establish an accurate baseline upon which to base future planning. Strategies aiming to decrease disparities and improve the health of East Oakland residents must involve those who are knowledgeable about the issues and have the ability to make an impact on the lives of individuals, as well as the vitality of the community.

Community physicians who have been providing culturally competent care while running successful small businesses for generations, are key to the health and vitality of the East Oakland community. These “Community-Rooted Providers” have displayed their commitment to caring for low-income families who face multiple challenges and barriers to good health. They also employ community members, serve as role-models for younger generations, provide a stable source of medical, social and psychological support, and are a voice speaking on behalf of the health of the community. These physicians and their practices are critical resources within the community that will be of even greater value with the implementation of the ACA. This report provides a firsthand account of the status of these physician practices, examining factors such as access, practice case mix, succession planning, and current and future capacity.

Findings of this report indicate that Community-Rooted Providers seeing patients in East Oakland comprise an important component of the Safety Net and, as such, should be included in future planning activities concerning ACA preparation. Healthcare policymakers are urged to utilize this report in their overall assessment of East Oakland’s Safety Net, and consider undertaking similar assessments of Community-Rooted Providers in other communities with poor health outcomes and limited resources. The inclusion of Community-Rooted providers in planning, decision-making and allocation of resources will ensure a more complete approach to addressing care of the underserved. Through this type of coordinated and cooperative effort, stakeholders can ensure the stability, perseverance and expansion of culturally competent, high-quality points of access to healthcare, and make a measurable positive impact on the health of the entire East Oakland community.



Community physicians who have been providing culturally competent care while running successful small businesses for generations, are key to the health and vitality of the East Oakland community.



INTRODUCTION

2.

Statement of the Problem at Large ●

Focus on East Oakland ●



These “Community-Rooted Providers” have provided cost-effective care to low-income communities for generations of residents, yet they have largely been left out of the conversation with respect to their role in the Safety Net.

Statement of the Problem at Large

The Safety Net has been defined by the Institute of Medicine as “those providers that organize and deliver a significant level of healthcare and other related services to uninsured, Medicaid, and other vulnerable patients”. Small, independent practices that care for the low income, underinsured and uninsured have been a critical part of the Safety Net for decades. While these practices receive low reimbursement or are uncompensated for seeing low-income patients, they generally do not receive additional resources or assistance to support these services to the community. These “Community-Rooted Providers” have provided high quality, culturally competent cost-effective care to low-income communities for generations of residents, yet they are often not part of the conversation with respect to their role in the Safety Net.

These points of access, which have always been critical to the health of the community, are now even more critical with the changes coming to the Healthcare Industry under the Affordable Care Act. Healthcare reform promises to provide healthcare coverage to millions of currently uninsured patients. Simultaneously, additional demands are being placed on healthcare providers such as electronic health records adoption, meeting meaningful use criteria and implementing the patient-centered medical home model. Nationwide, many private physicians who have traditionally provided care to Medi-Cal patients are choosing to retire or scale back their practices in response to these demands; few new physicians are entering primary care, and even fewer are entering private practice.^{1, 2}

Independent practices, including non-FQHC (Federally Qualified Health Center) clinics and independent physician practices that have chosen to care for low-income patients have managed to do so despite low reimbursements that stay flat while overhead costs continue to rise. These providers have made a commitment to serving their community despite these difficult realities, yet the system that is currently in place is inadequate to ensure their survival under the Affordable Care Act.

Other Safety Net providers such as FQHC’s and public clinics also face uncertainty as to the future of their reimbursement levels as well as difficulty retaining provider staff. They may also have concerns about maintaining market share with the arrival of Accountable Care Organizations, patients having new provider options, and other providers who may choose to compete for newly insured patients. While these providers have had a central role in caring for the nation’s low-income population for



Caring for low-income African-American patients in East Oakland has its challenges. Providers must give care that is culturally competent, trauma-informed, timely and accessible.

years, it is unlikely that any one system of care will be able to handle the significant increase of newly covered individuals. Thus, it is important that all stakeholders work together to maintain, strengthen and increase existing points of access that are critical to the health of low-income communities across the nation.

Focus On East Oakland

Health and healthcare disparities for East Oakland residents remain amongst the most troubling in Alameda County. The root causes are multi-factorial, but limited healthcare access compounds the situation. Many community clinics are at or near capacity, have extended wait times for new as well as established patients, and have limited capacity for uninsured patients. The nationwide trend of private physicians retiring or scaling back their practices with few new physicians taking their place could have a particularly devastating effect in East Oakland where there is already a shortage of health professionals.³ Therefore one of the goals of this study is to assess current and projected healthcare access and capacity among private practices and small clinics serving East Oakland residents.

Caring for low-income African-American patients in East Oakland has its challenges. Providers must give care that is culturally competent, trauma-informed, timely and accessible. There are also multiple barriers keeping East Oakland residents from receiving care, including unreliable transportation, inadequate childcare, inability to afford to travel, mistrust of medical institutions and their associated providers, fear of a medical diagnosis and fear of medication side effects, among others (see section 8). In order to overcome these barriers, providers should ideally be conveniently located nearby, provide culturally competent care and be knowledgeable about the community they serve. In fact, it was found that two-thirds of poor and near-poor Californians say it is important for their healthcare provider to understand their ethnic or cultural background, and three-quarters want their provider to know what is going on in their community.⁴

In order to achieve adherence to preventative health screening schedules and compliance with chronic disease management, the barriers of fear and mistrust must also be overcome. A high level of trust in one's healthcare provider has been shown to increase adherence to treatment nearly threefold. It is also one of the most important variables found to promote patient satisfaction with their care.⁵

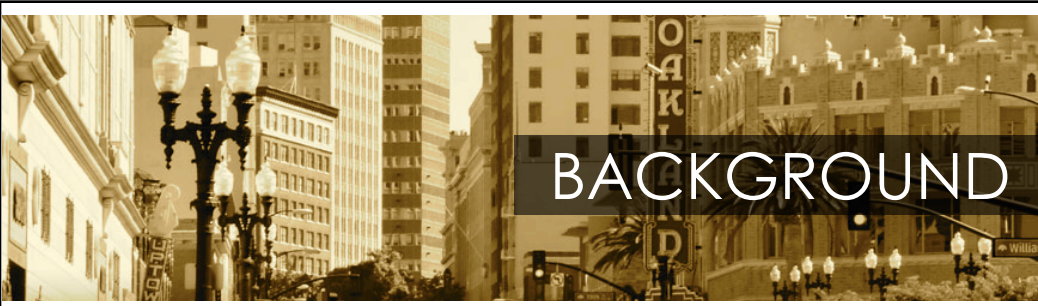
INTRODUCTION 2.

Many community physicians seeing low-income patients have been local, familiar and trusted healthcare providers for generations. For these reasons, an assessment of access to care for East Oakland residents must include these practices. However, to our knowledge, no evaluation-oriented project has been performed to study these independent practices from the inside out, and no assessment has considered the capacity, service delivery models and future viability of these practices as critical components of the Safety Net. A formal assessment and necessary action regarding East Oakland provider capacity and supply is critical to the health of its residents. In fact, in a recent capacity assessment of Alameda County Safety Net, it was pointed out that “Several providers discussed the need to increase the focus of care for specific populations such as the re-entry population, and some mentioned that Health Care Services Agency should try to build much more capacity with African American providers.”⁶

Because Community-Rooted Practices are private, independent, and physician-led, obtaining data on their current state and needs required individualized, in-depth and personalized contact with the physician specifically. To that end, Alameda County Health Care Services Agency contracted with Roots Community Consulting, a division of Roots Community Health Center, to perform this assessment. Roots is a California Department of Health Licensed Health Center and is a 501(c)3 organization dedicated to reducing health disparities in East Oakland, California and ensuring health equity for low-income communities across the country. Roots’ team of consultants have extensive experience in a broad range of medical practice models, from private practice to federally qualified health centers, and have a particular interest in ensuring the future sustainability of culturally competent, high quality medical practices in East Oakland in this era of healthcare reform.



Because Community-Rooted Practices are private, independent, and physician-led, obtaining data on their current state and needs required individualized, in-depth and personalized contact with the physician specifically



BACKGROUND

3.

A. East Oakland Demographics and Health Status ●

B. Community Empowerment and Cultural Competence ●

In recent years, the focus has increased on the impact of disparities on minority communities, with public officials, community activists, civic leaders and healthcare experts proposing ways to improve access to medical care and raise awareness of positive benefits of preventive care. The 2010 National Healthcare Disparities Report documented that racial and ethnic minorities often receive poorer care than Whites while facing more barriers in seeking preventive care, acute treatment or chronic disease management.^{7, 8}

According to an ongoing survey of primary care provider availability within the census tracts comprising East Oakland's predominant MSSA's (Medical Service Study Areas), the ratio of low income patients to all providers who will see them (inclusive of private practice, public and other clinics, and Federally Qualified Health Centers) is approximately 5500:1.⁹ This is far above the 3500:1 ratio that classifies an area as a Health Professions Shortage Area. Given the unacceptable health status of East Oakland residents, and the shortage of providers seeing low-income patients within East Oakland, it is critical that a comprehensive assessment of healthcare access for East Oakland residents be undertaken in order to establish an accurate baseline.



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A. East Oakland Demographics and Health Status

Contained within the City of Oakland, the East Oakland Service Area is comprised of the following 20 Census Tracts: 4073-4076, 4084-4089, 4091-4097, and 4102-4104. East Oakland covers all of zip codes 94603, 94621 and 94602, as well as parts of 94605.¹⁰

Educational Attainment

Residents of East Oakland have significantly lower levels of formal educational attainment when compared to Alameda County as a whole. Just 57% of East Oakland residents over 25 years of age have a high school diploma or GED, compared to 82% for Alameda County as a whole, and only 7% attained a Bachelor's degree or higher, compared to 35% for Alameda County as a whole.¹²

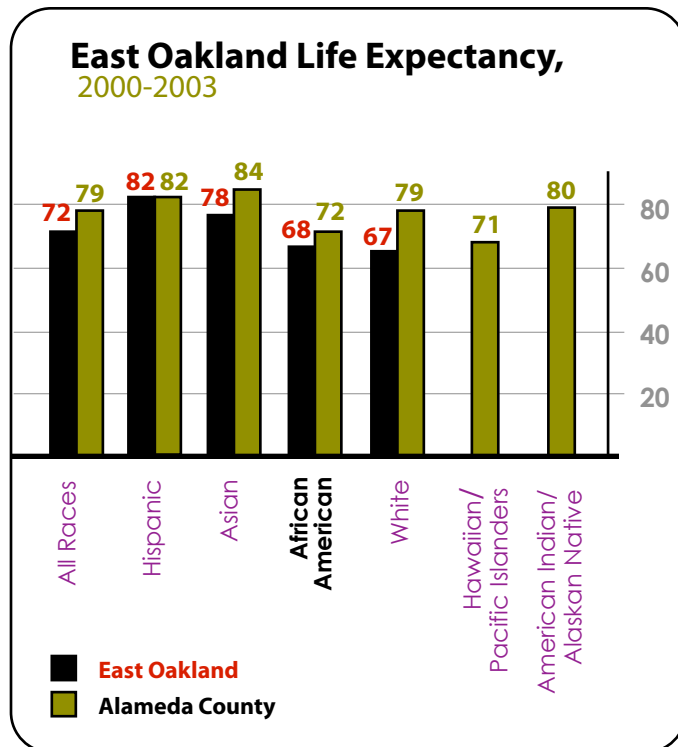
Income and Employment

East Oakland households experience high rates of unemployment and poverty as compared with the county as a whole. Nearly half of East Oakland's households (48%) earned an income of less than \$30,000, compared to 26% in Alameda County as a whole. And 16.7% of East Oakland residents over age 16 were unemployed, as compared to 6.1% in Alameda County overall.¹¹ As shown in Appendix C, there is a high concentration of households living under 200% of poverty in East Oakland (51.9%, 2007-2011).

Health Disparities

Significant health disparities between East Oakland residents and those of Alameda County as a whole, demonstrate the clear need for high quality, culturally competent accessible healthcare services. In fact, in order to overcome these disparities, the availability of these services should actually exceed the availability of similar resources in other parts of Alameda County.

The all-cause mortality rate is higher in East Oakland than in Alameda County as a whole, particularly for cancers, heart disease, stroke and homicide.



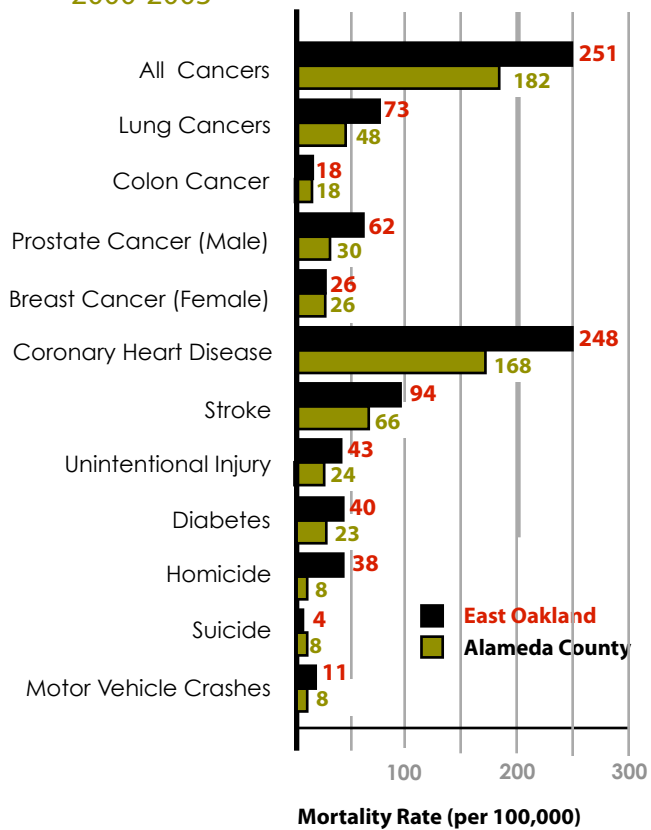
Source: Alameda County Public Health Department. Community Assessment, Planning, and Education (CAPE) Unit. East Oakland Community Information Book Update, October 2005.

African Americans in East Oakland are disproportionately represented in a variety of categories of leading causes of death, particularly heart disease, cancers, stroke, homicide, and unintentional injuries. And while all-cause mortality rates among individual race/ethnic groups has declined significantly per year since the mid 1990s, the gap between African Americans and the other race/ethnic groups is the widest it has been in recent history.¹³

Current Health Conditions

As compared to Alameda County and the State of California, East Oakland residents display a variety of health disparities, including obesity and mental health issues. Among children, principal concerns are childhood obesity and fair or poor health.

East Oakland Mortality Rate, 2000-2003



Source: Alameda County Public Health Department, Community Assessment, Planning, and Education (CAPE) Unit. East Oakland Community Information Book Update, October 2005.

Current Health Conditions	East Oakland %	Alameda County %	California %
ADULTS (18-40)			
Obese	32%	13%	21%
Overweight	29%	27%	32%
Diagnosed with asthma	8%	11%	14%
Fair/poor health	32%	15%	16%
Serious psychological distress in the last year	22%	6%	7%
Binge drinking in the last year	34%	36%	39%
CHILDREN (0-17)			
Teen overweight and obesity	48%	25%	29%
Diagnosed asthma (age 2-17)	15%	19%	15%
Fair/poor health	13%	5%	7%

Health Care Access and Utilization	East Oakland %	Alameda County %	California %
No doctor visit in the last year	35%	27%	24%
Visited emergency department in the last year	30%	13%	18%
Delayed getting prescription drugs or medical care in the last year	15%	23%	22%

Healthcare Utilization

Source: UCLA Center for Health Policy Research. Building Healthy Communities: East Oakland Health Profile

Adults in East Oakland are more likely to have visited the emergency room, and less likely to have visited a doctor in the last year than their counterparts in the rest of Alameda County and California as a whole.

Also, even when they have healthcare coverage, African-American patients in Alameda County disproportionately utilize the emergency department. Appendix D illustrates a snapshot of this phenomenon, whereby African Americans represented just 15% of enrollees in the county low-income health program, while they made up 43% of covered frequent emergency department utilizers (more than 3 visits in the 2nd quarter of 2011).

Insurance Coverage

East Oakland adults and children have a lower likelihood than individuals in Alameda County or the State of California of having insurance coverage from an employer or private provider, and have a significantly greater likelihood of being insured by a government program.

East Oakland also has high rates of residents who are eligible, yet not enrolled in county coverage or Medi-Cal (Appendix E).

Current Insurance Coverage	East Oakland %	Alameda County %	California %
ADULTS (18-40)			
Uninsured	21%	16%	22%
Insured by government program	27%	11%	17%
Insured by private coverage/employer	52%	72%	61%
CHILDREN (0-17)			
Uninsured	3%	3%	5%
Insured by government program	58%	24%	38%
Insured by private coverage/employer	40%	73%	57%

Community-rooted providers are trusted, culturally competent institutions which, despite limited resources, have remained respected pillars of the community that influence patient behavior and outcomes daily.

B. Community Empowerment and Cultural Competence

Community empowerment requires that its people have the ability to speak on their own behalf and provide their own direction, particularly when it comes to basic services and service delivery. This empowerment must then be passed on to subsequent generations in order to continue shaping the future of the community and to preserve communal autonomy. Community empowerment and self-direction are of paramount importance when it comes to the provision of medical care. Patients enter the many types of healthcare settings as vulnerable humans who have historically experienced situations where their differences are not accommodated or respected by healthcare providers. Difficulties range from understanding informed consent and advance directive information, accessing needed services, or denial of services to outright discriminatory treatment. It has been shown that, particularly among Black patients, racial bias and stereotyping are associated with markers of poor visit communication and poor ratings of care.¹⁴ These undesirable and unacceptable experiences are magnified by the historical and deep-rooted feelings patients may experience every day because of their socioeconomic, racial or ethnic group.

Community-rooted providers are trusted, culturally competent institutions which, despite limited resources, have remained respected pillars of the community that influence patient behavior and outcomes daily. They are community role models and community assets that represent true legacy institutions owned by the community they serve. These institutions also comprise an important component of the remaining Black owned businesses in East Oakland and are therefore important to the vitality of the community and its future. These practices should be viewed not only as sources for healthcare provision, but also small businesses that collectively have an economic impact on the community. Given that these small businesses are invested in the communities they serve, efforts to sustain and expand these practices will have an inherently positive impact on these communities and promote their resiliency. Thus, the perseverance and expansion of these culturally competent points of access to care is critical to the health of the people, to the economic vitality of the area, and to the self-direction and autonomy of the community.

METHODS & APPROACH

4.

Face-to-face interviews were conducted with private physicians seeing African American patients who reside in East Oakland. Physicians were drawn from lists of providers in the area registered with state Medical, Alameda Alliance, and Anthem Blue Cross, and snowball sampling was used to reach private primary care providers who have seen at least 200 African-American residents of East Oakland in the preceding twelve months. Interviews were conducted utilizing an interview guide and a locally developed survey instrument, abstracting quantitative data from Electronic Health Records (EHRs) or practice management software when possible.

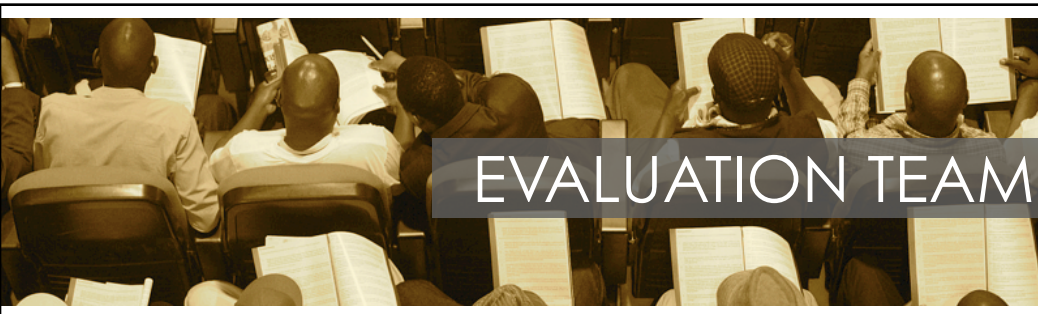
Initially this study was intended to focus on primary care providers only, however it was ultimately expanded to include specialists as well. This was done in an attempt to capture a more complete picture of the reality of care for low-income African-American patients in East Oakland as it was determined that some of the primary care providers focus their practice within a particular specialty area, and, more commonly, some of the specialists also provide primary care.

To ensure that interview and survey results could be optimally used to inform local healthcare reform policy, the interview guide and survey instrument were developed in collaboration with Damon Francis, MD, the Medical Director of the Urban Male Health Initiative within the Alameda County Public Health Department.

The interview sample included 33 practices: 11 specialists and 22 primary care providers. Providers that did not meet the above-referenced inclusion criteria based on their patient population were excluded from the statistical calculations reported herein, but their comments were included in Section 8 (Non-Respondent Stakeholder Views) below. Survey responses were collected and reported below for 16 primary care providers and 7 specialists. All information pertaining to specific practices remains confidential.



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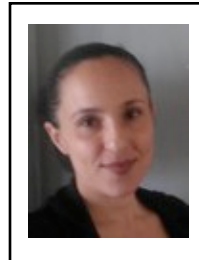


EVALUATION TEAM

5.

Noha Aboelata, MD

Chief Executive Officer
Roots Community
Health Center



Bennie L. Brown, MD

Chief Medical Officer
Roots Community
Health Center



Aquil Naji

Chief Operations Officer
Roots Community
Health Center



Daniel Muhammad

Director of Policy & Planning
Roots Community
Health Center



Noha Aboelata, MD and **Bennie Brown, MD** were the principal investigators performing the one-on-one interviews, site visits, surveys, data compilation and analysis. As fellow community physicians interested in the needs and concerns of these providers, Drs. Brown and Aboelata were granted unprecedented access to their practices and were encouraged overall by their candor and willingness to share personal and professional experiences, confidential business information and historical perspective.

Aquil Naji and **Daniel Muhammad** were instrumental in the study design, structure and facilitation of focus groups, and report preparation. Daniel Muhammad completed the graphics and layout for this report

SCOPE OF ASSESSMENT

6.

Interviews

Face-to-face interviews and focus groups were less structured and free flow of information and ideas was encouraged. A wealth of qualitative and historical data was gleaned from these discussions. While much of this valuable information is beyond the scope of this report, relevant comments as well as widely held sentiments have been included herein.

Study Limitations

There is no single resource identifying all providers who met the study criteria. Best efforts were made to reach the desired sample and while broadly inclusive, the sample is not exhaustive.

The provider pool is dynamic. New providers meeting the study criteria continue to be identified even up to the time of producing this report but are not included as the study period had closed. Also one provider retired during the course of the survey process, therefore those responses were removed.

Providers located in other geographic areas (such as Hayward, West Oakland, etc.) may meet inclusion criteria because they serve residents of East Oakland, but time did not permit exploring a broader geographical area.

Many practices are not functioning in an electronic environment so data in these cases was largely based on physician and staff reporting. Additional follow-up and access to paper records would be required to do a more in-depth assessment of daily practice, productivity, cash flow, revenue cycle, etc.

Study Focus

Current and projected capacity

Current patient case mix

Current and potential business models

Current and potential service delivery models

Practice sustainability

Ability to expand

Support needed to sustain and/or expand practice

Plans for future of practice/ succession planning

Data gathering and analysis activities

Ability to respond to changes brought about by health care reform

Relationships with other community providers

Barriers to good health for patients

Progress towards Electronic Health Records and Meaningful Use

Quality Assurance and Improvement activities

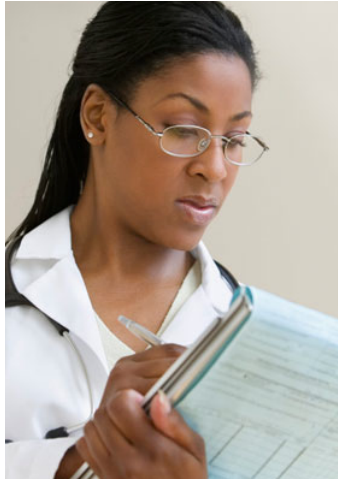


INTERVIEW & SURVEY FINDINGS

7.

- A. General** ●
- B. Physician Support** ●
- C. Billing** ●
- D. Barriers to Good Health for Patients** ●
- E. Plans for Future of Practice (Succession Planning)** ●
- F. EHR/MU** ●
- G. Career Satisfaction** ●
- H. Economic Recession and Affordable Care Act Impact** ●
- I. Quality Assurance and Improvement Activities** ●
- J. Provider Community** ●
- K. Business/Service Delivery Model** ●
- L. Practice Capacity** ●
- M. Provider Needs and Concerns** ●

INTERVIEW & SURVEY FINDINGS 7.



eighty-two percent of the physicians surveyed have been in community practice for over 20 years.

A. General

Ninety-six percent (**96%**) of survey respondents are of African descent, compared with 3.5% of physicians nationwide.¹⁵ The reason for this difference is that most private non-African-American physicians seeing patients from East Oakland do not accept Medi-Cal and do not see a significant number of African-American patients. Thus, although some of these physicians' comments were included in Section 8 below, they were excluded from the survey itself.

Ninety-one percent (**91%**) of the physicians surveyed are male, compared with 33% nationwide. The reason for this discrepancy is due to the age of the physicians serving this community. While the survey did not specifically ask the age of the physicians, **eighty-two percent of the physicians surveyed have been in community practice for over 20 years.** Numbers of female graduates have been steadily increasing: in 1965, only 7% of medical school graduates were female, compared to 50% today.¹⁶

Sixty-four percent (**64%**) of respondents are solo practitioners, **9%** are owners of a medical corporation, **9%** are an owner of a group practice and **18%** have formed a non-profit corporation. The vast majority, 73%, are not employed anywhere outside of their practice.

All of the providers surveyed have a patient population that is greater than 25% African-American; **75%** of the providers interviewed have patient population that is greater than 60% African-American. Other races are represented in smaller numbers: **82%** of practices have a patient population that is less than a quarter Latino and less than 39% Caucasian (half of the practices saw less than 10% Caucasian patients), and all had less than less than 10% Pacific Islander and less than 25% Asian patients. Sixty-four percent (**64%**) of the practices see primarily patients who reside in East Oakland (60% of patients in the practice). The remaining geographic distribution of the patient population is primarily from West Oakland and North Oakland, with smaller numbers coming from San Leandro, the Oakland Hills and Contra Costa County.

B. Physician Support

The majority of doctors surveyed (**65%**) do not employ midlevel providers in their practices. Of the remaining practices half (**17%**) employ Physician Assistants while the other half (**17%**) employ Nurse Practitioners. The average number of provider full-time equivalents (FTE's) per practice is 1.5, while the average number of support staff (medical assistants, receptionists, etc.) FTE's is 3.2. This translates into just 2.13 staff persons per provider, far lower than industry benchmarks which are 4 to 5 support staff per provider.^{17, 18} Physicians cited salaries as the obvious reason for not hiring more staff. Several stated that if they had the means they would employ midlevel providers and additional support staff, or that they have done so in the past but could not afford to continue to do so.



2 = the average number of staff per provider, far lower than industry benchmarks which are 4 to 5 support staff

The majority of primary care physicians surveyed (**73%**) utilize hospitalist groups when patients are admitted to the hospital, leaving only **27%** who provide in-patient care for their patients. However, nearly all (**92%**) do take telephone call in some form (for their practice only, or as part of a shared on-call group), leaving only 8% who do not take any call. Seventy-two (**72%**) percent of

physicians surveyed work more than 40 hours per week, with **36%** working more than 60 hours per week. The average split between patient care and administrative time was 32% administrative time and 68% patient care. Physicians interviewed indicated that they would prefer to have more patient care time but that the paperwork burden requires significant administrative time to complete.

C. Billing

Most of the practices surveyed (**72%**) perform their billing "in-house", while **28%** of the practices outsource their billing services. Eighteen percent (**18%**) of the doctors actually prepare and submit insurance claims themselves. Fifty-four percent of the practices have an employee do the billing, usually a support staff member who performs other duties as well. The majority (**72%**) utilize paper billing encounters. Of those, **36%** submit paper claims to the insurance companies, while the remaining **64%** have them converted into electronic claims. Eighteen percent (**18%**) of the practices have a billing system that is integrated with their practice management system or electronic health record.

The greatest concern physicians cited with their billing process (**60%**) pertains to the appeal and



forty percent of physicians say that they are unsure about the effectiveness of their billing process.

rebilling of rejected claims. Following that, 45% are concerned with claims rejection, and 36% percent cite that the delay between time of service and the time a claim is submitted as well as the delay between the time a claim is submitted and the time payment is received are of concern as well. Of note, **40%** of physicians say that they are unsure about the effectiveness of their billing process.



...in half of the cases, their patients live in unsafe environments and 45% of the time, they are dealing with too many life stressors (financial, family, etc.) and have limited access to healthy food.

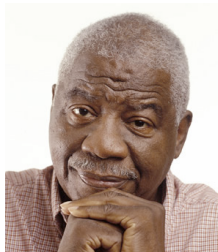
D. Barriers to Good Health for Patients

The most common conditions seen in the practices surveyed, in order of prevalence are: **Obesity, Diabetes, HTN, Addiction, Depression/Anxiety/PTSD, and Asthma** (highest in pediatric practices). The majority (**60%**) of physicians state that in at least half of their patient encounters they do not have enough time to provide the education they need. They also state that in half of the cases, the patient does not use the information they have or are otherwise non-compliant. **Ninety six percent (96%) of providers said they performed their own medication reconciliation and 86% percent perform their own patient education.**

Physicians estimated that in half of the cases, their patients live in unsafe environments and that **45%** of the time, they are dealing with too many life stressors (financial, family, etc.) and have limited access to healthy food. In approximately thirty percent of cases, patients are dealing with substance abuse issues.

Access to mental health services and home health services was ranked as poor or very poor by **45%** of physicians surveyed. Access to specialty care in general was also ranked as poor or very poor by **40%** of respondents. Poor access to mental health was cited by **45%** of physicians surveyed as a major concern. Home health access was also ranked as poor or very poor by **33%** of the physicians. Laboratory access was cited as an issue by **20%** of physicians, but was of particular concern among physicians whose practice location is in East Oakland, with nearly all of them (**90%**) **citing laboratory access as poor or very poor.** Pharmacy, DME, radiology and hospital access were ranked as being good by the majority (**70%** or more) of physicians surveyed.

60% of physicians state that in at least half of their patient encounters they do not have enough time to provide the education they need.



Most of the uncertainty around succession planning was related to the lack of new physicians coming into private practice who may want to assume an existing practice

E. Plans for Future of Practice & Succession Planning

When asked about their career plans over the next five years, **54%** of physicians surveyed stated that they planned to expand their current practice, while the remaining 46% stated that they were unsure. Many of these indicated that their uncertainty was due at least in part to the impending changes being brought about by healthcare reform. When asked to describe their ideal retirement, **18%** stated that they would like to retire within the next 5 years, **36%** indicated that they would like to retire in 6 to 10 years, **18%** said they would like to retire in 11 to 20 years, and 18% were undecided.

Most of the physicians surveyed (**64%**) indicated that they would like to leave their practice to another provider, but in most cases did not have any such physician identified. Nine percent indicated that their “exit plan” was to sell their practice, while 27% were unsure. Most of the uncertainty around succession planning was related to the lack of new physicians coming into private practice who may want to assume an existing practice. **Physicians stated that low reimbursement rates and uncertainty of income was the major factor keeping new physicians from entering their practice area.** They also feel that new graduates are not aware of the potential opportunities in private practice. Many also felt that the work of private practice is perceived as too strenuous by new graduates. Physicians surveyed did not feel that undesirability of the neighborhood or too much time in the hospital or on-call were factors keeping new physicians from entering the area.

36% indicated that they would like to retire in 6 to 10 years

64% indicated that they would like to leave their practice to another provider, but in most cases did not have any such physician identified

F. EHR/MU

There is significant variability among the practices with respect to progress towards Electronic Health Records. Twenty seven percent state that their practice has a fully implemented EHR, all charts have been abstracted and retired and they are no longer using paper charts. Nine percent (9%) state that their practice has a fully implemented EHR but that all charts have not been retired yet. Another 27% have purchased an EHR system but have not installed it or have not begun implementation yet. Finally, 36% do not have an EHR system yet.

Of those who do not yet have an electronic health record, half stated that it was because they are too expensive. Another 25% stated that they did not have time to investigate, purchase and implement an EHR system, and 21% felt that there was not enough buy-in from staff or providers. Four percent stated that they are considering being acquired by a hospital or other organization and would therefore wait to obtain their system.

Only 44% of the physicians surveyed believed that they were meeting meaningful use criteria, and on track to receive the first round of meaningful use payments. Another 27% doubted they would be eligible for the first round of MU payments, but plan to become compliant before the next round. Twelve percent doubted they would become compliant with Meaningful Use, while 17% were unaware of what Meaningful Use is.



Electronic Health Records Implementation:



Have fully implemented EHR, all charts have been abstracted and retired- no paper charts



Have a fully implemented EHR but all charts have not been retired yet



Have purchased an EHR system but have not installed it or have begun implementation.



Do not have an EHR system yet.

Of those who do not have an EHR:



Stated that it was too expensive to purchase



Stated that they did not have the time to investigate, purchase and implement an EHR system



Felt that there was not enough buy-in from staff or providers



80%
of physicians surveyed
indicated that they
were either very
satisfied (40%) or
mostly satisfied (40%)
with their career.

...compared to **39%**
of who reported
being mostly or
very satisfied in a
nationwide survey.

G. Career Satisfaction

Eighty percent (**80%**) of physicians surveyed indicated that they were either very Satisfied (**40%**) or mostly Satisfied (**40%**) with their career. Twenty percent (20%) stated that they were sometimes satisfied and sometimes unsatisfied, while none reported being mostly or very unsatisfied. This is compared to **39%** of physicians who reported being mostly or very satisfied in a nationwide survey of 13,575 physicians.¹⁹

When asked how they would advise their child (grandchild, niece, nephew, etc.) about whether to pursue a career in medicine, **54%** stated that they would encourage them to become a physician, **27%** stated that they would give a neutral or unbiased opinion, and **9%** said that they would encourage them to go into the healthcare field, but not as a physician. This is compared with 42% of doctors who would discourage young people from going into medicine in the 2012 nationwide Physicians Foundation Survey.

Interestingly, all of the physicians sampled stated if they could go back in time with respect to their career choices, that they would still become a physician.

Eighty-two (**82%**) percent would not do anything differently, while **18%** would have chosen a different specialty or sub-specialty. This is compared to 66.5% of physicians in the 2012 Physicians Foundation survey who stated they would go into medicine if they had it to do over again. Increased satisfaction and outlook among these Community-Rooted Providers compared to their counterparts (most of whom are more highly-compensated) was attributed to feelings of personal fulfillment, having appreciative patients and a sense of making an impact on their patient population.

With regards to the impact of the Affordable Care Act (ACA), 87% believe that it will improve patient access to care and 72% believe that it will improve the quality of healthcare.

H. Economic Recession and Affordable Care Act Impact

Physicians were asked how the economic recession affected their practice. Thirty nine percent (39%) said they have had to cut costs/reduce overhead to stay profitable. Seventeen percent (17%) said they have to see more patients to stay profitable, another 17% have had to seek other sources of income, and another 17% have sold assets or use savings/reserves in order to stay in business. Thirty five percent (35%) say that the recession has not affected their practice.

With regards to the impact of the Affordable Care Act (ACA), 87% believe that it will improve patient access to care and 72% believe that it will improve the quality of healthcare. Eighty percent (80%) believe it will improve patients' control over their healthcare. Physicians were split as to how the ACA will impact physician's control over their patient care, with 30% believing it would decrease their control, 30% believing it would not decrease it, and 40% were unsure. Physicians were also divided as to how the ACA will impact physician's control over their practice management, with 44% believing it would decrease their control, 33% believing it would not decrease it, and 22% were unsure. Half of the physicians were unsure as to whether the ACA would be costly to comply with, twenty percent thought it would be costly and 30% did not. Several physicians added that any increase in regulations, paperwork or compliance would be burdensome.

Forty five percent (45%) of respondents stated that they believe they are ready for the changes that will be brought about by the ACA. Another 36% said that they were not currently ready, but believe that they will be ready in time for the ACA mandates. Nine percent (9%) say they may not be ready when ACA mandates take effect and 9% say they don't know what the ACA requirements are.

96%

of physicians surveyed do not use clinical data except to treat individual patients.

4%

systematically use CQI on a portion of their patients/visits and **13%** are utilizing CQI on their entire practice population.

95%

of physicians responded that they would be willing to provide their expertise or speak on relevant topics to a group of community physician

I. Quality Assurance and Improvement Activities

Ninety-six percent (**96%**) of physicians surveyed do not use clinical data except to treat individual patients. Four percent (**4%**) gather and analyze clinical data regularly and make indicated changes. Eighty-three percent (**83%**) are not using clinical CQI (Continuous Quality Improvement) to improve patient care in their practice.

Four percent (**4%**) systematically use CQI on a portion of their patients/visits and **13%** are utilizing CQI on their entire practice population. Several of the recent adopters of Electronic Health Records indicated that they planned to begin analyzing clinical data for their practice with the new tools available to them. Most providers understood the benefits of CQI but stated they do not have time to do it.

J. Provider Community

Physicians surveyed belong to local groups for networking and social activities, as well as state and national associations related to their specialty or medicine in general. Others belong to IPA's which may provide information and vehicles for clinical and business practice improvement. Many of the physicians surveyed have long-standing relationships with fellow community providers: **70%** have social relationships, **40%** networking and **40%** clinical collaboration relationships and **50%** have some type of business relationship with their colleagues. Ninety-five percent (**95%**) of physicians responded that they would be willing to provide their expertise or speak on relevant topics to a group of community physicians.

80%

of physicians surveyed state that Medi-Cal (including Medicare/Medi-Cal) was their first or second-most important source of revenue.

50%

stated that Medicare was their first or second most important source of income.

26%

of the providers have greater than 25% uninsured (low-income) patients in their practice, while only 8.6% have a contract to see these patients

65%

of physicians surveyed were not familiar enough with Accountable Care Organizations (ACO's) to discuss their opinions

36%

do not believe that a Concierge Practice is right for them or their patients,

K. Business/Service Delivery Model

Eighty percent (**80%**) of physicians surveyed state that Medi-Cal (including Medicare/Medi-Cal) was their first or second-most important source of revenue. Another **50%** stated that Medicare was their first or second most important source of income. HMO income was cited as the most important income source by 10% of the doctors surveyed.

With respect to actual patient care mix, **90%** of physicians surveyed have greater than 30% Medi-Cal in their practice and another **14%** have >30% Medicare/Medi-Cal. Fifty-five percent of the practices have more than a quarter of their population with Medicare coverage. Twenty percent cited PPO income as their most important source of revenue, although the majority (**88%**), have less than 25% of their patients having PPO coverage. This is attributed to significantly higher per-visit reimbursement for these patients.

All providers (**100%**) have less than 25% fee-for-service (moderate to high income) patients. Twenty-six percent of the providers have greater than 25% uninsured (low-income) patients in their practice, while only 8.6% have a contract to see these patients. The other physicians who see uninsured patients do so on a sliding fee scale or irrespective of their ability to pay, primarily under the following circumstances: they continue to provide care to previously insured patients after they lose their insurance coverage; they see uninsured family members of established patients; they see patients despite lack of coverage as per their mission or historical role in the community.

Sixty-five percent (**65%**) of physicians surveyed were not familiar enough with Accountable Care Organizations (ACO's) to discuss their opinions, concerns or plans with regards to ACO's. Seventeen percent do not believe that ACO's are right for them, but did not mind them in general, while another 17% believe they are bad for medicine.

Sixty-three percent (**63%**) of physicians surveyed were not familiar with Concierge Practices, 36% do not believe that a Concierge Practice is right for them or their patients, but do not mind if other physicians have them and another 36% believe that Concierge Practices are bad for medicine or for patients.

INTERVIEW & SURVEY FINDINGS 7.

fee-for-service ?
licensed facility
2014 Medi-Cal
network ACO MEDICARE
concierge practice? non-profit
non-profit IPO

Eighteen percent (**18%**) of physicians in the survey are not familiar with fee-for-service practices. Eighteen percent (**18%**) already run a fee-for-service practice, and another 18% are currently considering shifting to a fee-for-service practice. Forty-five percent (**45%**) do not believe that a fee-for-service practice is right for them or their patients, but do not mind if other physicians have them.

Thirteen percent (**13%**) of providers surveyed have state licensed facilities. Eighty-two percent (**82%**) of those not licensed said they would consider licensure in the future if they found it to be beneficial, while others did not know enough about the benefits to consider it.

Eighteen percent (**18%**) of respondents' practices are non-profit entities. Seventy-eight percent (**78%**) of those who are not a non-profit entity would consider becoming one in the future. Thirty-four percent (**34%**) of practices surveyed employ midlevel providers. Of those who do not, **87%** would consider doing so in the future if it was economically feasible and they were appropriately trained in their specialty or sub-specialty.

Only **60%** of practices have a website. Fifty percent (**50%**) of primary care physicians said they market themselves through community events, twenty percent through social media, **20%** through newspaper and **20%** via social media.



...already run a **fee-for-service** practice, and another **18%** are currently considering shifting to a fee-for-service practice



...of providers have **state licensed facilities**. (**82%**) of those not licensed would consider it in the future if found beneficial.



practices are **non-profit entities**. Seventy-eight percent (**78%**) of those who are not a non-profit entity would consider becoming one in the future



of practices **have a website**. (**50%**) market themselves through community events, (**20%**) through social media, **20%** through newspaper

L. Practice Capacity

Practice capacity was considered for primary care providers only. This included OB/Gyn providers, although some of their patients also see a primary care provider. This is roughly offset by the specialists who also see primary care patients. The average number of patients per practice is **2245**, with a range of 800 or less (two practices less than 1 year old) to 5000. **On average, 3.5 patients are booked per hour and on average 3.0 seen per hour.**

All providers surveyed stated that they have the capacity to grow in their current space. Twenty-six percent (**26%**) stated that they could see double or more than double the number of patients in their current space but would need additional support staff. Twenty-six percent stated they could grow by 10-25% and another 48% could increase by 26-40%. For the sixteen primary care providers surveyed, the total patient population is approximately 36,000 patients. Based on their own estimates, the growth they have the capacity for is approximately 10,000 to 11,200 patients.

Seventy-eight percent (**78%**) of primary care providers are accepting new patients from all payer sources. Twenty-two percent (**22%**) of primary care providers are taking new patients, but are limiting certain payers. All of the specialty providers are accepting new patients from all payer sources. Eighty-two percent (**82%**) of primary care providers are completely open to both Medi-Cal and Medicare (if applicable) patients. Eighteen percent (**18%**) are limiting Medi-Cal patients, and none are completely closed to Medi-Cal or Medicare. This is in contrast to findings in a nationwide survey of over 6500 physician practice owners that showed that 38.8% of physicians were closed to Medi-Cal and 11.7% were closed to Medicare.²⁰

All of the providers surveyed who are limiting Medi-Cal state they are doing so because reimbursement is too low. Even among those who are not limiting Medi-Cal currently, there was sensitivity to the overall practice case mix and not wanting to be “overwhelmed” by Medi-Cal patients due to the low reimbursement they come with. For those limiting Medi-Cal patients, some limit the number per month they will accept



Based on their own estimates, the growth they have the capacity for is approximately 10,000 to 11,200 patients

100%

Providers that have capacity to grow in their current space

26%

Said they could see double or more than double the number of patients in their current space

INTERVIEW & SURVEY FINDINGS 7.

while others periodically “close” and “reopen” to Medi-Cal patients. Some providers indicated that they were in a “holding pattern” with respect to Medi-Cal and felt that they could easily see more Medi-Cal patients if compensation were appropriate. All providers stated that they would not stop seeing low-income patients altogether because of their history of providing care to low-income patients, however they did express serious concerns about the viability of their practices if regulations and overhead continued to increase without a commensurate increase in reimbursement. This sentiment was echoed primarily among the adult medicine and family practice providers, and less-so by pediatric providers.

Seventy-four percent (74%) of physicians were unsure about their plans with respect to staffing over the next twelve months. Eighteen percent (18%) plan to hire more support staff while 8% plan to hire provider staff. Physicians commented that their uncertainty was due at least in part to concern about the impact of the ACA on their practice and their financial ability to expand during these uncertain times.

Forty-five percent (45%) of primary care provider respondents say they do not make enough salary to compensate them for the number of hours they work. Eighty percent (80%) of specialists feel that they have reasonable compensation with a reasonable workload, compared with 36% of primary care providers. Five percent (5%) say they may not be in business within the next one year because of financial hardship.

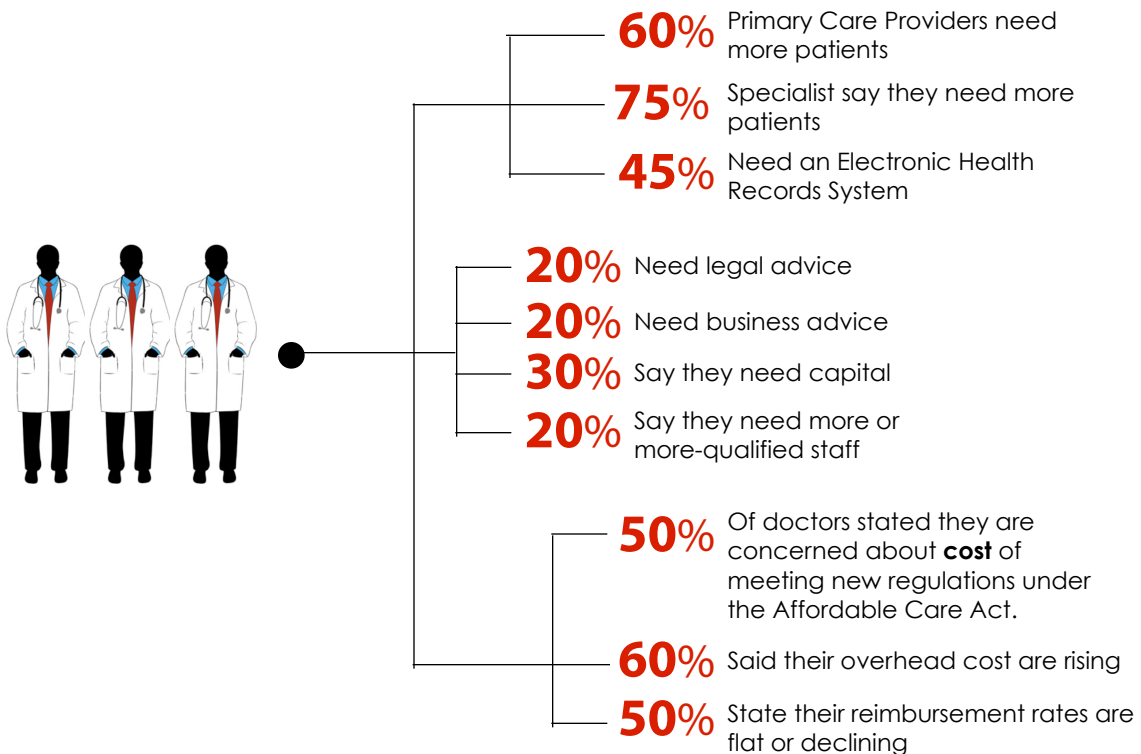
Some providers indicated that they were in a “holding pattern” with respect to Medi-Cal and felt that they could easily see more Medi-Cal patients if compensation were appropriate

82%
of primary care providers are completely open to both Medi-Cal and Medicare

45%
of primary care provider respondents say they do not make enough salary to compensate them for the number of hours they work

M. Provider Needs and Concerns

Providers were asked to report their immediate needs. Sixty percent (60%) of primary care providers and 75% of specialists say they need more patients, although only 20% said they need marketing assistance. Forty-five percent (45%) need an Electronic Health Records System and 40% need legal or business advice. Thirty percent (30%) said they need capital, and 20% said they need more or more-qualified support staff. Fifty percent (50%) of doctors surveyed state that they are concerned about the cost of meeting new regulations under the Affordable Care Act. Sixty percent (60%) say that their overhead costs are rising while 50% state that their reimbursement rates are flat or declining.





FINDINGS BEYOND THE SURVEY

8.

Informal interviews with multiple stakeholders were performed in order to obtain a broader picture of East Oakland's Safety Net. This included focus groups and discussions with survey respondents and other stakeholders. This section is meant to provide an overview of these findings and is not meant to imply a comprehensive or systematic assessment of the views of any group mentioned.

Meetings and discussions were held with key staff in the following: local and statewide foundations; Alameda Alliance for Health (predominant managed care Medi-Cal plan); Alameda Health Care Services Agency, Alameda County Public Health Department, Alameda County Social Services Agency, Community Based Organizations, local ancillary service providers (pharmacy, laboratory and home health) and local politicians.

Local ancillary service providers and other stakeholders confirmed that patient satisfaction with Community-Rooted Providers is generally high. In fact, many reported that patients convey a sense of pride regarding their "private doctor" or "family doctor". Recognition of Community-Rooted Providers as a part of the safety net was initially limited but was ultimately understood. Challenges facing these providers, particularly under ACA, were also initially under-appreciated by many. The reason cited for this lack of awareness was simply that the role and plight of non-FQHC Providers had not been specifically articulated in the context of care of the underserved. Of note was the repeated observation from leaders and policymakers that while they knew of a small handful of private practice doctors in the East Oakland community, they had not yet heard a unified voice speaking for community providers serving low-income African-American patients.

Concerns about the future viability of independent practices in general, and providers who serve low-income patients in particular, were raised. **Many acknowledged that a loss of private providers willing to see low-income patients would leave a significant void for African-American patients in East Oakland, but they were not clear about the magnitude of this void.** Many were aware of the impending aging out of several

- **Local ancillary service providers and other stakeholders confirmed that patient satisfaction with Community-Rooted Providers is generally high. In fact, many reported that patients convey a sense of pride regarding their "private doctor" or "family doctor"**
- **repeated observation from leaders and policy makers that while they knew of a small handful of private practice doctors in the East Oakland community, they had not yet heard a unified voice speaking for community providers serving low-income African-American patients**

FINDINGS BEYOND THE SURVEY 8.

physicians seeing low-income patients in East Oakland, a lack of succession planning and paucity of new providers-particularly primary care providers-entering the area. Several raised concerns about the preservation of culturally competent points of access to care for elderly African-American patients in particular.

Interviews were also held with physicians that did not meet inclusion criteria (employed by a hospital, FQHC or medical group, too few African-American patients, resident physicians, NP's, PA's). Desire among providers of color to practice in low-income communities of color was high. Reasons cited by physicians not coming into independent practice centered on instability of their income, uncertain future of private practice and concerns about being isolated, without any support network. Several private practice physicians who do not accept Medi-Cal, particularly those newer to practice or new to the area, expressed interest in caring for low-income patients but were concerned about low reimbursement levels and practice viability.

Many survey respondents attended focus groups where topics beyond the survey were discussed, and others participated in interviews and individual discussions before or after the survey. Some primary care providers expressed concern about the high pill burden of many of their patients, particularly elderly patients seeing multiple specialists. Others who do not care for their patients in the hospital raised frustration about poor communication and access to records after hospital discharge. Some specialist providers expressed concerns about patient non-compliance and non-adherence to their scheduled appointments. Lastly, primary care providers reported that patients "assigned" to clinics and not able to get an appointment present to their offices for care, leading to a disruption in continuity of care and sometimes an increase in uncompensated care.

East Oakland Focus.

In-depth discussions with providers whose practices are physically located in East Oakland focused on barriers to accessing services and the lack of availability of such services in the East Oakland Service Area. Identified barriers that seem to affect this population disproportionately include:

Living in poverty
Recently released from incarceration/on parole
Addiction/substance abuse, including prescription drug misuse
Exposure to violence and trauma
Family responsibilities such as caring for grandchildren/great grandchildren
Lack of reliable transportation
Reliance on public support (welfare, unemployment, etc.)
Unemployment/underemployment
Inadequate health education resources
Lack of mentors/healthy and positive role models
Fear of needles , surgery, medication side effects
Mistrust of doctors/medical institutions
Fear of being diagnosed with cancer or other illness
Inadequate childcare resources and assistance
Fear of knowing their HIV status
Not wanting to disclose to family and friends that they are being tested or treated for a medical problem
Lack of social support
Low educational attainment
Delayed entrance into healthcare/prenatal care
Homelessness
Unstable or substandard housing
Mental health issues, including post-traumatic stress



CAPACITY FOR EXPANSION

9.

All providers surveyed indicated the desire and ability to expand with the proper support. For the sixteen primary care providers surveyed, the total patient population is approximately 36,000 patients, while the growth they have the capacity for is 10,000 to 11,200 patients, without adding providers or expanding space. This added capacity could reportedly come in several forms, including any or all of the following: adding hours or days for existing providers, expanding hours of operation and increasing patients seen per hour. These forms of expansion would require additional resources, particularly in the form of support staff and ancillary services such as billing. They would also require building out practice efficiencies that would streamline operations and allow the physician to spend more time on direct patient care.

In order for these expansions to succeed, provider case mix would need to be carefully considered. In the current environment, most physicians would be financially unable to solely target low-income patients for this expansion and would most likely need to preserve their current case mix. However, with additional resources that would help increase efficiency, decrease overhead or provide appropriate compensation, physicians would be well-positioned to assume significantly greater populations of low-income patients.

The capacity and desire for expansion is of paramount importance and should be considered in context. First, as previously mentioned, there are many providers who were not included in this survey who would contribute to these patient numbers (those identified too late in the survey process, those in outlying areas, etc). There are also providers not currently caring for low-income patients who have the desire to do so, and given favorable conditions could later be added. Conversely, providers surveyed are not solely seeing patients in East Oakland, and it could be assumed that the geographic distribution of their patients would roughly be preserved. Most importantly, it should be noted that there are too few providers located within East Oakland itself providing care to low-income patients, and that if proper resources were available, and if the provider to patient ratio increased to levels seen in other areas of the county, capacity would increase tremendously.

In the current environment, most physicians would be financially unable to solely target low-income patients for this expansion and would most likely need to preserve their current case mix. However, with additional resources that would help increase efficiency, decrease overhead or provide appropriate compensation, physicians would be well-positioned to assume significant populations of low-income patients



10.

The primary challenge for Community-Rooted Providers is balancing their role in the community seeing significant numbers of low-income patients with the reality of running a sustainable business. Aside from their personal commitments to continue caring for low-income patients, there is nothing obligating these providers to continue doing so.

One of the most pressing concerns facing Community-Rooted Providers is the successful adoption of electronic health records. Without financial support and/or technical assistance to make the transition into an electronic environment, many of these providers run the risk of being left behind.

Community-Rooted Providers are accustomed to practicing independently and in general do not have formal connections with other practices, clinic consortia, residency programs, etc.

Private practitioners also generally work longer hours than their employed counterparts²¹ and have limited time to stay abreast of changes that specifically affect their practices or to take advantage of programs that may benefit them.

low-income patients

reimbursement

sustainability

ACA requirements

quality healthcare access

cultural competency

- The primary challenge for Community-Rooted Providers is balancing their role in the community seeing significant numbers of low-income patients with the reality of running a sustainable business.

- Without financial support and/or technical assistance to make the transition into an electronic environment, many of these providers run the risk of being left behind.



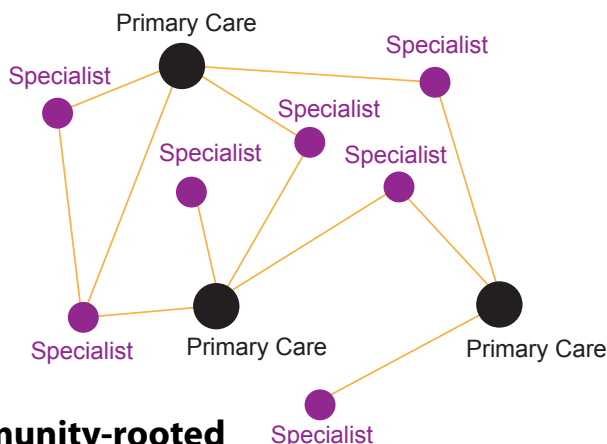
11.

Relationships among Community-Rooted Providers are already established. Providers are committed to referring patients to one another and communicating with one another about the care of their patients. They are also willing to share best practices and spend their personal time interacting with their colleagues.

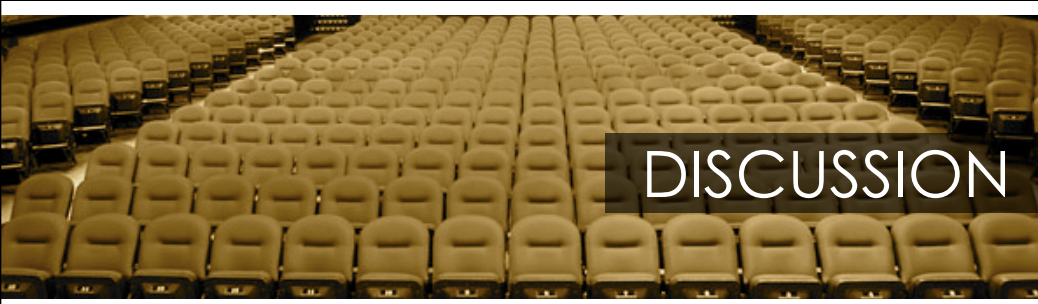
Community-Rooted Providers have practices in strategic locations, and have a cultural connection to the community. They also have solid and loyal patient populations, often spanning generations and including families, neighborhoods, and entire communities. Providers have high levels of career satisfaction as well as the desire to continue and to expand their practices. This presents the potential to create mentorship opportunities and a “pipeline” for residents and other providers who have interest in community practice. It is also promising that providers have a positive view of working with midlevel providers and are open to practice expansion using physician extenders.

Community-Rooted Providers have practices in strategic locations, and have a cultural connection to the community. They also have solid and loyal patient populations, often spanning generations and including families, neighborhoods, and entire communities.

EAST OAKLAND | 2014 healthcare access



**community-rooted
providers network**



12.

Healthcare reform introduces a tremendous challenge to the current healthcare system in America: millions of new enrollees that need care despite the low reimbursement rates they come with. In order to effectively meet this challenge, it is imperative that practices that have traditionally served these populations not only survive, but that they thrive, increase their scale and attract new providers to do the same. The challenge of increasing points of access to high-quality, culturally-competent care will be greatest in low-income communities of color where health disparities are already the widest, and access is already the most challenging.

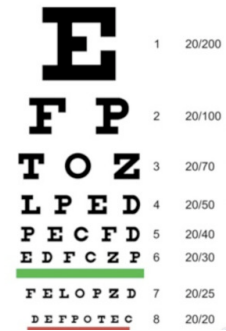
In general, small and medium-sized community practices fulfilling the role of providing care to low-income patients do so independently. There is no network that connects these community institutions; no infrastructure in place that provides self-direction and stability. Such a network infrastructure could serve to strengthen the resiliency of the each of the practices. Education and strategic knowledge regarding the ACA and likely competitors will allow a strategic planning process that ensures financial viability and critical insight into the present and emerging healthcare landscape.

The ACA includes provisions to strengthen the safety net delivery system, improve access to providers, promote greater workforce diversity, strengthen data collection and implement an array of prevention and public health initiatives. There must be a viable and well informed provider infrastructure to take advantage of these offerings. With the increasing demands of medical practice today including the challenges brought about by healthcare reform, it has never been more critical that organizations with aligned missions and priorities work together.

The ACA includes provisions to strengthen the safety net delivery system, improve access to providers, promote greater workforce diversity, strengthen data collection and implement an array of prevention and public health initiatives. There must be a viable and well informed provider infrastructure to take advantage of these offerings.

The findings of this survey illustrate that there is a strong base of providers who are committed to caring for low income populations facing some of the greatest challenges to good health. These providers display amazing dedication and resiliency, surviving the ever-changing healthcare climate. Of note, these providers experience greater job satisfaction than their counterparts with more affluent practices and have the desire to leave their practice to another community provider as opposed to selling it to a larger outside entity. These findings represent promise that with some coordination and support, future generations will continue to benefit from Community-Rooted Providers committed to their health and well-being.

Emerging from this evaluation process was a particular concern that must be addressed: providers seeing low-income African American patients do not articulate their needs, or the needs of their patients, with a unified voice. This seems largely due to the fact that these providers are busy providing valuable care to their patients and meeting the demands of their practice. As these demands increase, and as the number of patients needing care also increases, it is critical that these providers are able to build scale while maintaining a level of quality and cultural competency that is required to care for this challenging patient population. **Without the proper network and support, the concern is that these providers will discover that they cannot continue to afford to provide the same amount of uncompensated or undercompensated care, and invaluable community resources will be lost.**



Emerging from this evaluation process was a particular concern that must be addressed: providers seeing low-income African American patients do not articulate their needs, or the needs of their patients, with a unified voice.



RECOMMENDATIONS

13.

A. Recommended Actions for Community-Rooted Providers

B. Recommendations for Healthcare Policy Makers

One of the most important findings of this report is that there remain a number of providers committed to serving low-income African-American patients despite the challenges they face. These practices have been resilient businesses and respected community institutions for generations. It is critical that these practices be sustained and expanded in order to ensure culturally competent, trusted points of access under the ACA. Findings of this report suggest that this will best be accomplished through the implementation of the following recommendations:

A. Recommended Actions For Community-Rooted Providers

1.

Community-Rooted Providers can no longer afford to function in silos. **A network of culturally competent community providers serving or willing to serve low-income patients should be formed.** This network should consider centralizing common functions, utilizing economies of scale and building efficiencies as a group. Activities should focus on the immediate needs and concerns of the providers as well as planning for the future of this critical component of the Safety Net.

2.

Immediate needs, as identified in the survey may include **collaboration on Electronic Health Records purchase** and implementation; **group purchasing of equipment and supplies**; reducing overhead by **sharing resources, collective billing, shared call and shared marketing**; increasing practice efficiency by **providing health education, training** and other resources to practices and their patients.

3.

Planning for the future requires ongoing education, exchange of ideas, sharing best practices, and making a measurable positive impact on the lives of patients. **Providers should work quickly and continuously to ensure that a pipeline of new providers with similar commitment to care for the underserved will continue to practice in and advocate for the community.** Importantly, this Community-Rooted Provider Network should set its own priorities and present a unified voice to articulate and elevate the health status of the community and to help inform healthcare policy.

B. Recommendations for Health Policymakers

While the Affordable Care Act promises to increase access to *healthcare coverage*, its effect on access to a source of *healthcare* has yet to be seen. In fact, it is likely that currently underserved populations will continue to be underserved and that healthcare access for low-income patients will become even more difficult. As more patients receive Medi-Cal coverage under the ACA, it is critical that culturally competent access points for these patients be maintained and expanded. To that end, healthcare policymakers should consider the following actions:

1. Encourage and ensure representation of Community-Rooted Providers at all tables where decisions around healthcare for low-income patients are being made.
2. Make provisions to prevent the emergence of a “digital divide” whereby low-income community providers remain in a paper environment, isolated and left out of opportunities available to those entities who adopt electronic health records.
3. Support innovations that result in the provision of accessible, cost-effective, culturally competent care for selected, high-need patient populations.
4. Consider strategies to increase mental health care capacity for low-income patients such as facilitation of primary care-mental health integration initiatives.
5. Facilitate programs such as loan repayment, internships and job training that ensure a pipeline of physicians, midlevels, mental health providers and allied health professionals will continue to provide services to the community.
6. Consider a formal assessment of private healthcare providers for other low-income populations and geographic areas to determine needs and capacity.
7. Provide financial support to Community-Rooted Provider Networks who see a significant number of low-income patients.
8. Consider measures of access, clinical quality and cultural competency in pay-for-performance and other quality improvement initiatives.
9. Consider a model whereby coverage “follows the patient” in order to provide fair compensation to non-county contracted providers for services rendered.
10. Consider contracting with Community-Rooted Providers directly or via provider networks to increase access for low-income patients.
11. Collect data on availability of specialty care to inform efforts to improve and expand access.
12. Determine what ancillary services are needed in what specific geographic areas and facilitate their establishment.

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APPENDIX A

Survey Instrument - part 1


Physician Survey


Physician Name _____

I participated in the Roots Community Health Alliance Provider Survey. I fully support the efforts and goals of this survey as they were explained to me. I consent to being contacted in the future confirming my participation in this project. I have been assured by Roots Community Consulting that all of my responses will be de-identified and that any information provided by me in this survey will be maintained in the strictest confidence.

Signature

Date

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State of the Physician Survey

Date: _____ Interviewer: _____

Introduction:
With recent pressures, economic forces and ACA demands, we are concerned about the present state and future of private practices. This survey was designed to assess the current state of the private practice physician so that we may design programs and services to address our needs. Your responses will be maintained in the strictest confidence. Results of the survey will be aggregated and you will be provided with the full report upon our completion.

Physician name: _____
Address: _____
Tel#: _____
Physician race/ethnicity: _____
Email: _____

A. Basic information about you and your practice

1. Which best describes your practice (check all that apply)?
 Primary care (specify: _____)
 Specialty (specify: _____)
 Multi-specialty (specify: _____)
 Surgical specialty (specify: _____)
 Other (please specify): _____

2. What is your practice type?
 Solo practice
 Owner/partner in group practice
 Non-profit
 Medical corporation (how many owners? ____)
 Other (please specify): _____

3. Are you employed as a physician?
 Employee of a group
 Medical director (where?: _____)
 Hospital employee
 Clinic or community health center employee
 Other (please specify): _____

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4. Do you have mid-level providers in your practice?
 Yes, Nurse Practitioners
 Yes, Physician Assistant
 Yes, Nurse Practitioners and Physician Assistants
 No

5. How many total provider FTE's in your practice? _____
(____ you; ____ other MD's; ____ midlevels; ____ other: _____)

6. How many staff FTE's in your practice? _____

7. How do you take care of patients when they go to the hospital?
 I (or my partner) see patients in the hospital
 Hospitalists see my patients in the hospital
 Other (please specify): _____

8. How many hours per week do you work on average?
 Less than 20 hours per week
 20-30 hours per week
 30-40 hours per week
 40-50 hours per week
 50-60 hours per week
 More than 60 hours per week

9. What is the split between your admin time and patient care time?
Administrative: _____ hours/week
Patient care: _____ hours/week

10. Please estimate the race/ethnicity of your patient population
____ % Black/African/African-American
____ % Latino
____ % Asian
____ % Pacific Islander
____ % White/European
____ % Other: _____

11. Please estimate the geographic distribution your patient population
____ % from East Oakland
____ % from West Oakland
____ % from North Oakland
____ % from Oakland Hills
____ % from San Leandro
____ % Other: _____
____ % Other: _____

12. Would you be willing to provide your expertise or speak on relevant topics to a group of community physicians?
 Yes. Possible topics: _____
 No


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APPENDIX A

Survey Instrument - part 2

Physician Name: _____ Date: _____



Physician Survey Part II

A. Support:

1. Who does the billing for your practice?

- I outsource billing services
- I hire a contractor to do my billing
- I have a highly trained staff person do my billing (FTE: _____)
- I have a staff member who also performs other functions do my billing (hours/week: _____)
- I do my own billing (hours/week: _____)

2. Which of the following best describes your billing system/process?

- My billing system is fully integrated with my practice management system or EHR
- I utilize paper billing encounters which are then converted by someone to electronic claims
- I utilize paper billing encounters and submit paper claims
- Not applicable/ I outsource billing services
- Other: _____

3. Which of the following best describes the effectiveness of your billing?

- My billing process results in payment of 90%-100% of what is owed to me by the payer source
- My billing process results in payment of 75%-90% of what is owed to me by the payer source
- My billing process results in payment of <75% of what is owed to me by the payer source
- Unsure
- Other: _____

4. On a scale of 0-5 (0=not an issue, 5=major issue), please rank your level of concern regarding the following items related to billing?

- ___ delay between time of service and time claim is submitted
- ___ delay between time claim is submitted and time payment is received
- ___ rejection of claims
- ___ appeal/rebilling of rejected or reduced claims

5. Do you take call?

- Yes, I take telephone and hospital call for my practice only
- Yes, I take telephone call for my practice only
- I am part of a shared on call group
- I do not take any call

6. How is patient education handled in your practice?

- I (or the provider) provide all patient education
- Medical assistants are trained to provide patient education
- RN's or LVN's provide patient education
- Health educators provide health education
- Other: _____

PAGE 1

7. How is medication reconciliation handled in your practice?

- I (or the provider) perform all medication reconciliation
- Medical assistants are trained to perform medication reconciliation
- RN's or LVN's perform medication reconciliation
- Health educators perform medication reconciliation
- Other: _____

B. Barriers to good health for patients

1. In your practice, what are the most common issues you are seeing and/or treating (rank in order)?

- ___ Diabetes
- ___ Hypertension
- ___ Obesity
- ___ Addiction
- ___ Asthma/COPD
- ___ Depression/Anxiety/PTSD
- ___ Other: _____

2. What barriers to good health exist for your patients? (True what %age of the time)

I do not have enough time to provide the education they need _____ %
 They do not use the information they have or are otherwise non-compliant _____ %
 They are dealing with too many life stressors (financial, family, etc.) _____ %
 They are dealing with substance abuse issues _____ %
 They have limited access to healthy foods _____ %
 They live in unsafe environments _____ %
 Other (please specify): _____ %

3. Rank your patients' access to care in the following areas:

	Very poor	Poor	Fair	Good	Excellent	N/A
DME						
Pharmacy						
Urgent Care						
Hospital Care						
Laboratory Services						
Radiology Services						
PCP's only:						
Specialty care						
Home Health						
Mental Health						
Specialists only:						
Primary care						

Comments: _____

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C. Plans for future of practice/succession planning

1. What are your career plans over the next five years?

- Expand my current practice
- Continue my current practice
- Close my practice
- Merge with another practice
- Sell my practice
- Retire at 65
- Retire early
- Join an Accountable Care Organization
- Not sure
- Other (please specify) _____

2. Which describes your ideal retirement?

- I wish I could retire now
- I would like to retire within the next 5 years
- I would like to retire in 6 to 10 years
- I would like to retire in 11 to 20 years
- I am undecided

3. What is your "exit plan"?

- Close my practice
- Sell my practice
- Leave my practice to another provider
- Not sure
- Other (please specify) _____

4. In your opinion, to what extent are these factors barriers to attracting new physicians to your practice area (0=not a barrier, 5=major barrier)?

- ___ Low reimbursement rate/uncertainty of income
- ___ Undesirable neighborhood
- ___ Work is too strenuous
- ___ Too much time on call or in hospital
- ___ New graduates are not aware of the potential opportunities in private practice

D. EHR/IMU

1a. Which statement best describes your progress towards Electronic Health Records?

- My practice has a fully implemented EHR, all charts have been abstracted and retired and we are no longer using paper charts
- My practice has a fully implemented EHR but all charts have not been retired (____% retired)
- My practice has an EHR but we are still in the process of implementation (when did implementation begin: _____)
- We have purchased an EHR system but have not installed/not begun implementation yet
- We do not have an EHR system yet

b. If no system yet, why?

- I am working on purchasing a system within the next: _____ months
- I do not have time
- Not enough buy-in (from me or other staff)
- They are too expensive
- We are waiting on an affiliate (hospital or other) to adopt
- We are considering being acquired by a hospital or other organization and will wait to obtain theirs

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- No time for training

2. Which statement best describes your progress towards meeting Meaningful Use?

- I am meeting meaningful use criteria, and am on track to receive the first round of MU payments
- I am unsure as to whether or not I am on track to receive the first round of MU payments
- I doubt I will be eligible for the first round of MU payments, but plan to become compliant before the next round
- I am not planning to be compliant / eligible for MU payments.
- I am not sure what meaningful use is
- ___ Explain: _____

E. Career Satisfaction

1. How satisfied are you with your career?

- Very Satisfied
- Mostly Satisfied
- Sometimes Satisfied/Sometimes Unsatisfied
- Mostly Unsatisfied
- Very Unsatisfied

2. If your child (grandchild, niece, nephew, etc.) wanted your advice about whether to pursue a career in medicine, how would you respond?

- I would encourage them to become a physician
- I would try to give an unbiased opinion
- I would encourage them to go into the healthcare field, but not as a physician
- I would discourage them
- Other (please specify) _____

3. If you could go back in time with respect to your career choices what would you do?

- I would not do anything differently
- I would still go into medicine, but would choose a different specialty/sub-specialty
- I would still go into healthcare, but not as a physician
- I would not go into healthcare at all
- Other (please specify) _____

F. Economic Recession and ACA impact

1. How has the economic recession affected your practice (check all that apply)?

- I have had to cut costs/reduce overhead to stay profitable
- I have to see more patients to stay profitable
- I have had to seek other sources of income
- I have had to sell assets or use savings/reserves in order to stay in business
- The recession has not affected my practice
- Other (please specify) _____

2. Please give your opinion on the impact of the Affordable Care Act in the following areas:

	Strongly Agree	Agree	Unsure/Neutral	Disagree	Strongly Disagree
Will improve patient access to care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will improve quality of healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will decrease physicians' control over patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Will decrease physicians' control over practice management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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APPENDIX A

Survey Instrument - part 2

Will be costly to comply with _____
Will decrease patients' control over their healthcare _____

3. How prepared do you feel you are for the imminent ACA requirements?
 I believe that I am ready for the changes that will be brought about by the ACA
 I am not currently ready, but believe that I will be ready in time for the ACA mandates
 I may not be ready when ACA mandates take effect
 I probably will not be ready for ACA mandates
 I don't know what the ACA requirements are
Comments: _____

H. Quality Assurance and Improvement activities

1. How are you using clinical data?
 I am not using it at all, except to treat individual patients
 I collect data on certain subsets of patients (explain: _____)
 I gather clinical data on all of my patients
 I gather and analyze clinical data regularly
 I gather and analyze clinical data regularly and make indicated changes

2. How are you using clinical CQI (Continuous Quality Improvement) to improve patient care in your practice now?
 I am not using it at all
 I am using it anecdotally, or on a case-by-case basis
 I am systematically using CQI on a portion of my patients/visits
 I am utilizing CQI on my entire practice population

I. Provider Community

1. What other organizations do you collaborate with now to effect improvement in your practice?

Organization	Type of improvement (clinical, business, etc)

2. Describe your relationships with other community medical providers (check all that apply).
 Social/personal
 Business relationships
 Collaboration (clinical)
 Networking
 None
 Other _____

J. Business/Service delivery model

1. What is your most important source of revenue (rank in order)?
____ FPO
____ Medicare
____ Medicaid
____ Medi/Medi
____ HMO
____ Fee-for-Service
____ Consultant Income
____ Medical Director Income
____ Salary (source: _____)

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____ Other: _____

2. Please estimate your practice case mix*?
FPO _____ %
Medicare _____ %
Medicaid _____ %
Medi/Medi _____ %
HMO _____ %
Fee-for-Service (moderate to high income) _____ %
Uninsured (low-income) _____ %

3. What are your plans with respect to an Accountable Care Organization (ACO)?
 I am not familiar with ACO's
 I have already joined an ACO
 I am currently considering joining an ACO
 I do not believe that an ACO is right for me or my patients, but I do not mind if other physicians have them
 I believe that ACO's are bad for medicine or for patients
 Other (please specify): _____

4. Would you consider shifting to a Concierge Practice?
 I am not familiar with Concierge Practices
 I already run a Concierge Practice
 I am currently considering shifting to a Concierge Practice
 I do not believe that a Concierge Practice is right for me or my patients, but I do not mind if other physicians have them
 I believe that Concierge Practices are bad for medicine or for patients
 Other (please specify): _____

5. Would you consider shifting to a Fee-for-service Practice?
 I am not familiar with Fee-for-service Practices
 I already run a Fee-for-service Practice
 I am currently considering shifting to a Fee-for-service Practice
 I do not believe that a Fee-for-service Practice is right for me or my patients, but I do not mind if other physicians have them
 I believe that Fee-for-service Practices are bad for medicine or for patients
 Other (please specify): _____

6. Is your facility licensed?
 Yes
 No
If not, have you/would you consider licensure?
 Yes
 No. (Why not?: _____)

7. Would you consider becoming a non-profit entity?
 Yes
 No
If no, why not?
 N/A, we are already a non-profit entity

8. Would you consider selling to a hospital or medical group?
 Yes
 No
If no, why not? _____

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9. Would you have you consider(ed) hiring midlevel providers?
 Yes
 No
If no, why not? _____
 N/A, we already employ midlevel providers

10. Are you a member of any IPA or MSO?
 Yes
 No
If yes, which one(s): _____

11. How do you market your practice (check all that apply)?
 Website
 Newspaper
 Community events
 Social media
 Email marketing
 Other: _____

K. Practice Capacity

1. Approximately how many patients total in your practice*? _____

2. Approximately how many active patients (seen once in past 2 years) in your practice? _____

3. On average, how many patients are booked per hour? _____

4. On average, how many patients do you see per hour? _____

5a. Are you accepting new patients?
 Yes I am accepting all patients
 Yes, but only certain payers: _____
 No. I am closed to new patients

b. If yes, how much can you grow?
 By 10-25 percent
 Could increase by about 26-40%
 Could increase by about 50%
 Could increase by 50-75%
 I could double
 I could more than double

c. If no, why not?
 I am at capacity
 I am scaling back
 Other: _____

6a. Which describes your current status with respect to MediCal and MediCare patients?
 I am closed to both MediCal and MediCare patients
 I am closed to MediCal patients
 I am closed to MediCare patients
 I am limiting both MediCal and MediCare patients
 I am limiting MediCal patients
 I am limiting to MediCare patients

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I am open to both MediCal and MediCare patients
 Other: _____
Comments: _____

b. If closed or limiting, why?
 Reimbursement too low
 Paperwork burden too high
 All of above
 Other: _____

7. Describe your plans with respect to staffing over the next 12 months:
 I plan on hiring provider staff (FTEs: _____)
 I plan on hiring support staff (FTEs: _____)
 I plan on laying off staff or otherwise downsizing (FTEs: _____)
 Unsure

8. Which of the following statements best describes your workload/compensation?
 I do not make enough salary to compensate me for the number of hours I work
 My practice affords me a reasonable salary, with a reasonable workload
 I must work more than full-time in order to make a reasonable salary
 I make a generous salary for the number of hours I work
 Other: _____

9. What are your immediate needs (check all that apply)?
 Capital
 Legal advice/resources
 Business advice/resources
 Marketing assistance
 More Patients
 An EHR system
 More/more qualified Staff
 Other: _____

10. Which of the following statements accurately describes your current situation (check all that apply)?
 I am concerned about the cost of meeting new regulations under ACA
 My overhead costs are rising
 Reimbursement rates are flat or declining
 I may not be in business within the next year
 I have drastically cut costs to stay in business
 I have borrowed money to stay in business
 I have tapped savings to stay in business
 I have sold assets to stay in business
 I am spending more money on collections
 I am dealing with increased patient bad debt

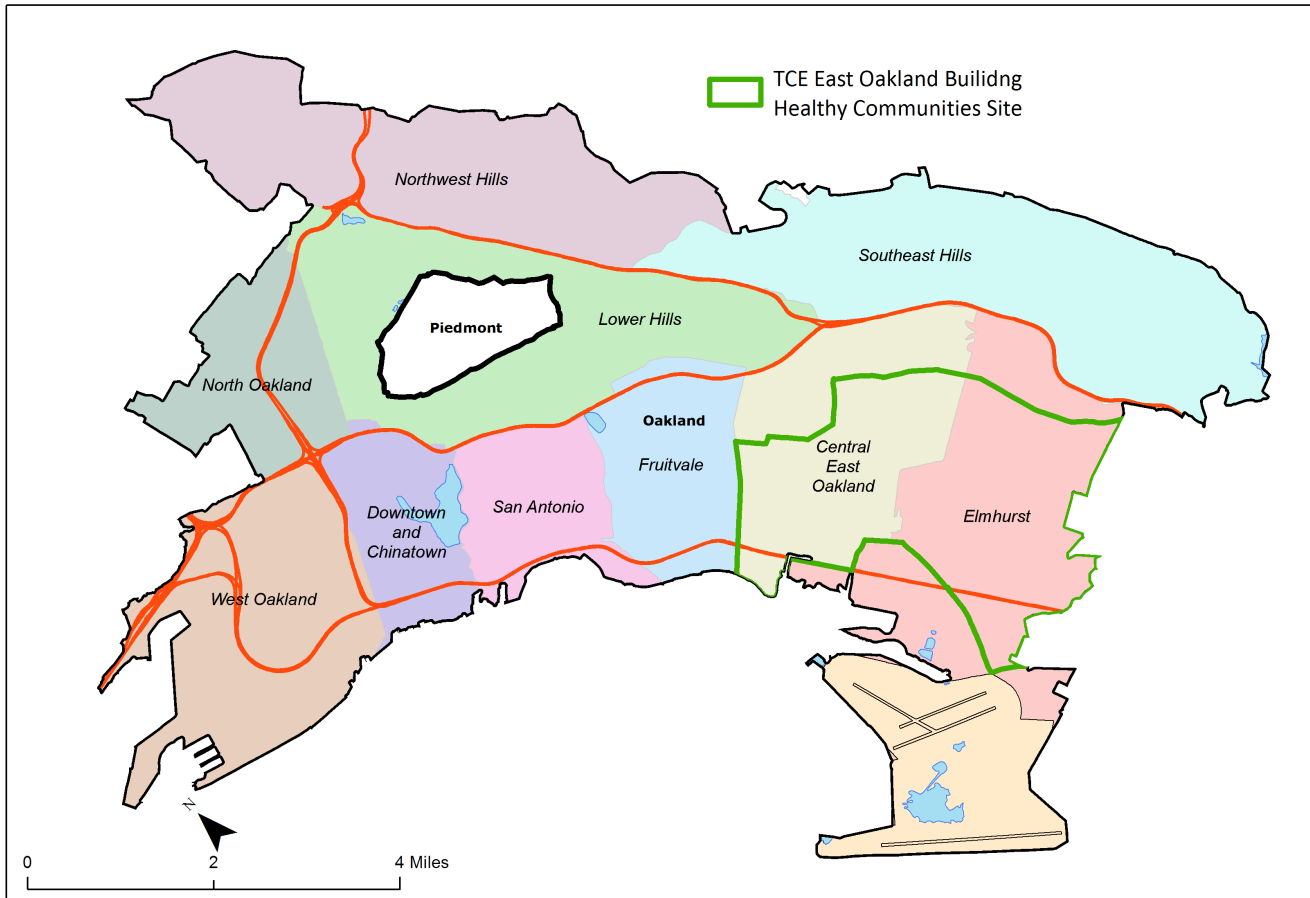
Thank you for your time. We appreciate your participation.

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APPENDIX B

Map of East Oakland

Oakland and 'East Oakland'

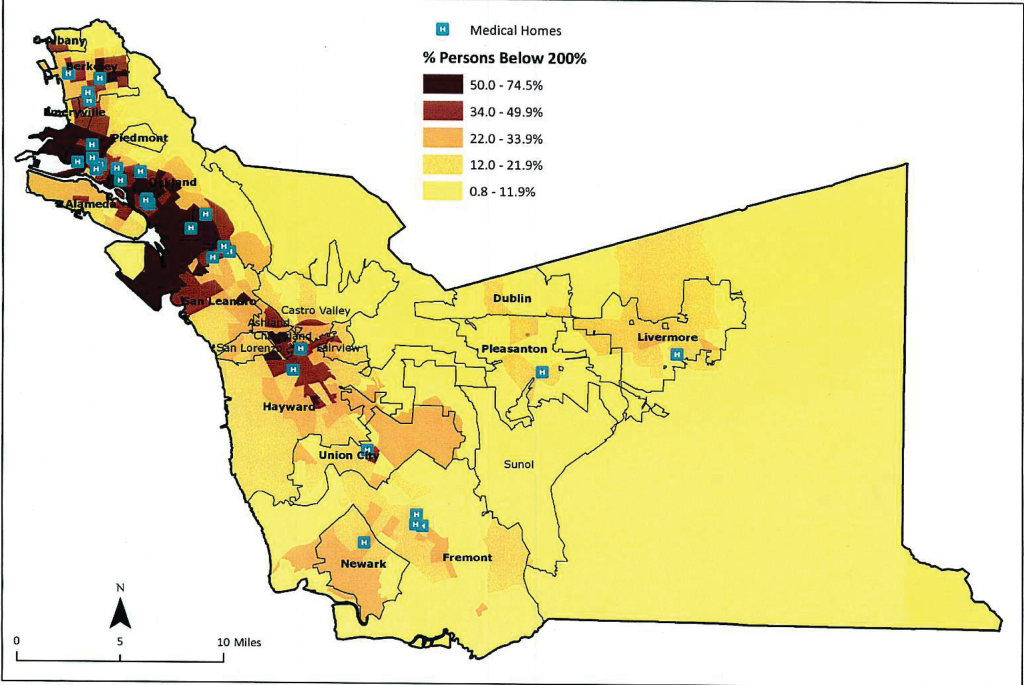


Source: CAPE.

APPENDIX C

Alameda County 200% Poverty Map

200% Poverty

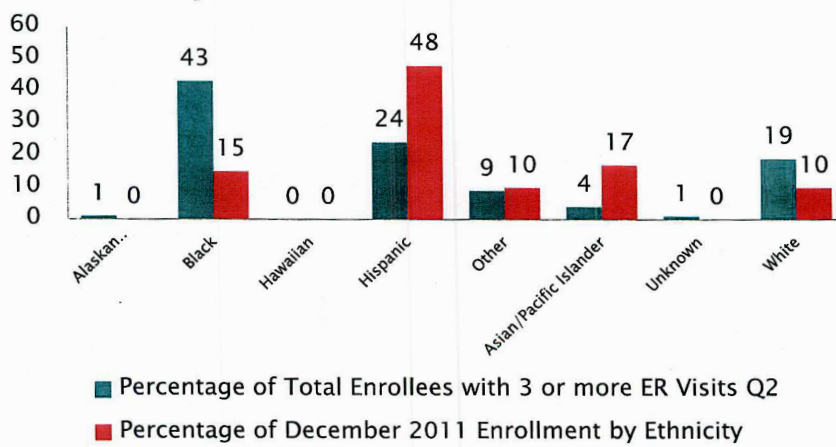


Source: CAPE, with data from HealthPAC 2012 and American Community Survey 2006-2012. Produced May 7, 2012.

APPENDIX D

Emergency Department Utilization Q2 2011
(County Low-Income Health Program Enrollees)
By Ethnicity

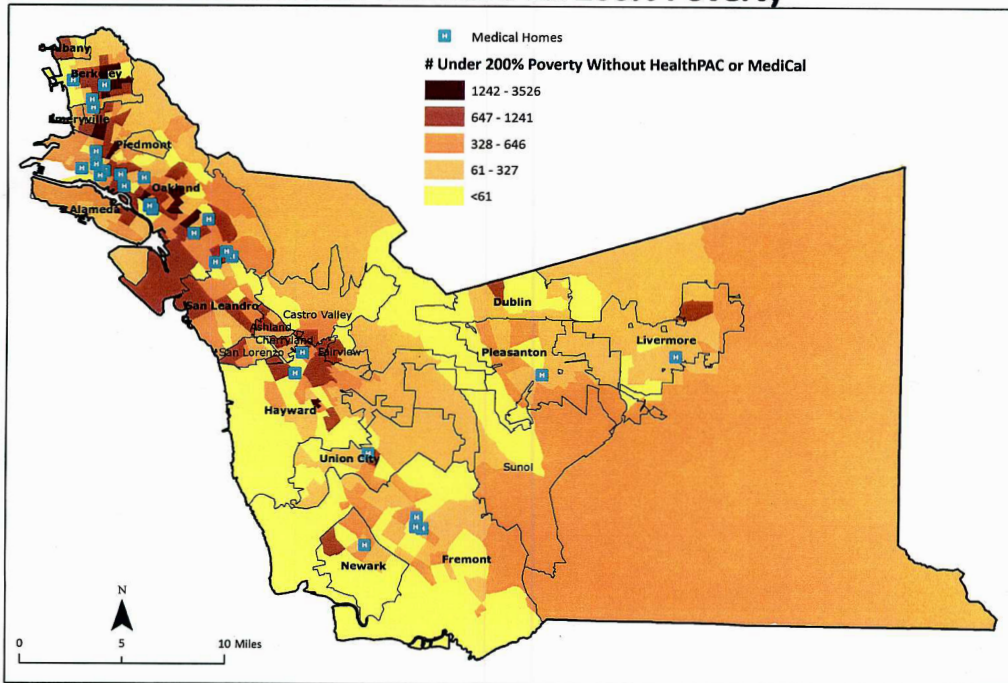
ER 3 or More Visits: Quarter 2 by Ethnicity



APPENDIX E

Eligible But Not Enrolled in County Low-Income Health Program

HealthPac and MediCal Enrollees vs. 200% Poverty



Source: CAPE, with data from HealthPAC 2012, Social Services Agency 2012, and American Community Survey 2006-2012.
Produced August 21 2012.