REDUCING DISPARITIES AND IMPROVING QUALITY: UNDERSTANDING THE NEEDS OF SMALL PRIMARY CARE PRACTICES

Robin M. Weinick, PhD; Sepheen C. Byron, MHS; Esther S. Han, MPH; Jessica Briefer French, MHSA; Sarah Hudson Scholle, DrPH, MPH

Objectives: Small practices provide a significant proportion of care in the United States and should be an essential focus of efforts to reduce racial/ethnic disparities and improve the quality of care for minority patients. This project sought to identify the resources and tools small practices need to conduct quality improvement activities to reduce disparities.

Design: We surveyed small practices about their capabilities for conducting quality improvement activities for minority and limited English proficiency patients. A subset of practices also completed a brief chart review.

Settings: Grantees of the National Committee for Quality Assurance Program were independent practices required to have five or fewer physicians with little or no experience with quality improvement (mean number of physicians = 1.4). At least one-quarter of the patients served by the practice were required to be minorities.

Participants: Twenty-two practices from California and New Jersey.

Main Outcome Measures: Surveys assessed clinician preparedness, use of systematic processes, and availability of information technology to improve care for minority patients. The chart review exercise elicited information on challenges and enabling factors in recent encounters with racial/ethnic minority patients.

Results: Small practices face considerable challenges in caring for minority patients. They have limited staff and fewer resources than larger group practices, increasing the difficulty of making improvements on their own. The main challenges identified were patient adherence to treatment recommendations, staffing, language barriers and lack of information systems.

Conclusions: Small practices will require substantial support from external organizations in order to contribute to national reductions in racial/ethnic disparities in health care. (*Ethn Dis.* 2010;20:58–63)

Key Words: Disparities, Quality Improvement, Small Practices, Primary Care, Race, Ethnicity, Language

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INTRODUCTION

Since the publication of the Institute of Medicine's landmark reports on healthcare quality and racial and ethnic disparities in care, there has been an increasing move toward pairing these two concepts and emphasizing quality improvement as a means of reducing disparities and improving health care for racial and ethnic minority patients.[1,2] To date, however, most efforts linking quality improvement and disparities have focused on large healthcare settings. The National Health Plan Collaborative, for example, is composed of major health insurance plans, and the Health Resources and Services Administration's Health Disparities Collaborative is composed of federally qualified community health centers.[3,4] Programs such as the Robert Wood Johnson Foundation's Speaking Together and Expecting Success focus on quality improvement and measurement for minority patients in hospitals.[5,6]

Despite this emphasis on large settings, however, small practices provide a significant proportion of care in the United States, with 77% of office visits in 2005 occurring in practices with 5 or fewer physicians.[7] Given this, it is critically important to understand how to implement a variety of quality improvement techniques in this setting in order to maximize the likelihood of reducing disparities. Small practices may face unique challenges to these activities, as prior work has demonstrated that the factors affecting performance cannot be generalized from large organizations to primary care practices, as they are smaller and generally have fewer resources for supporting quality improvement.[8]

In response to these concerns, the National Committee for Quality Assurance (NCQA), with funding from The California Endowment, launched a demonstration grants program for small physician-run practices to undertake one-year projects designed to improve the quality of care for their minority patients. In addition to financial support, NCQA provided technical assistance through national experts and locally based project partners in each area. The main goal of the project was to learn what types of resources and tools small practices needed in order to conduct and sustain quality improvement activities to reduce disparities. This article describes the results of an initial needs assessment conducted at the start of the project in order to better understand how to support the practices in their efforts.

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Address correspondence and reprint requests to Robin M. Weinick, PhD; The RAND Corporation; 1200 South Hayes Street, W7W; Arlington, VA 22206; 703-413-1100 x5151; rweinick@rand.org

METHODS

NCQA engaged its local partners, the California Medical Association Foundation (CMAF) in California and Health Care Quality Solutions, Inc. in New Jersey, to recruit and nominate primary care practices for the project. Each partner recommended 11 practices in their state. To be eligible for the project, practices were required to: be independent practices serving adult patients; have five or fewer physicians; have at least one-quarter of all patients served by the practice be from one or more minority racial/ethnic groups (as estimated by the lead physician in the practice); have a basic capacity to identify patients by characteristics or clinical condition; and have little or no prior experience with quality improvement methods.

Practices' needs were assessed using two tools. First, the lead physician from each office provided information about the practice and completed a survey as part of the enrollment process. The survey included both open-ended questions and structured questions drawn from NCQA's Physician Practice Connections (PPC) Readiness Survey, which assesses a practice's use of systematic processes and information technology to enhance the quality of patient care.[9] The needs assessment also included questions on clinicians' preparedness for caring for diverse patients drawn from Weissman et al.[10] Second, as a result of the efforts of CMAF, the practices in California completed an exercise regarding caring for diverse patients that consisted of reviewing 10 patient charts and answering open-ended questions about challenges and enabling factors in two recent patient encounters.

RESULTS

Twenty-two practices were recruited into the program. The practices had a wide range of financial arrangements, with 2%–65% of patients' primary payer being Medicaid, self-pay, or charity care (Table 1). While all of the participating practices were required to have at least 25% minority patients as estimated by the lead physician, in some practices virtually all patients were African American, Latino, or Asian. On average, physicians in California estimated that their practices included approximately two-thirds minority patients as compared with approximately half as estimated by the physicians in New Jersey. Practices also varied considerably in the proportion of their patients with limited English proficiency (2%–90%). As a group, the physicians and office staff in these practices spoke nearly 20 different languages in addition to English. The average number of practicing physicians was 1.4. Among the lead physicians, 32% were White, 41% Asian, 9% African American, 9% Latino, and 9% were Middle Eastern.

Table 1. Characteristics of practices participating in NCQA grant program

% of patients who				
Pay by Medicaid, self-pay, or charity care	Are from racial/ethnic minority groups	Have limited English proficiency	Languages other than English spoken by physicians and staff	Total number of physicians
27	35	10	Hindi, Urdu	1
2	30	*	None	1
65	80	15	None	2
17	30	10	Chinese, Malay	1
*	60	2	None	1
50	60	30	Spanish, Hebrew, limited French	1
20	99	45	Spanish	4
5	30	2	None	1
26	50	20	Hindi, Gujarati, Urdu, Tagalog, Spanish	2
*	65	*	Persian, Spanish, Tagalog	2
45	40	30	Arabic, Spanish, Vietnamese	3
30	30	30	Urdu, Punjabi, Arabic, Bangladeshi	1
65	90	90	Pilipino, Spanish	1
20	99	50	7 different Indian languages	1
30	80	35	Spanish	1
50	85	80	Spanish	1
60	30	50	Spanish, Italian, German, Vietnamese	1
30	50	30	Hindi, Spanish	1
*	95	80	Spanish	1
37	60	45	Hindi, Spanish	1
24	85	10	None	2
3	25	25	Spanish	1

* missing

The information physicians provided about the practice included a range of challenges to reducing racial and ethnic disparities in care. Only 2 of the 22 practices had fully functioning electronic health record systems, while 10 had paper records supplemented with some electronic system including registry, lab, radiology or electronic prescribing. The remaining 10 practices had only paper records. Many of the practices reported that they were unable to track race, ethnicity and preferred language of their patients; as a result, they were also unable to identify the quality of care provided specifically to

Table 2. Challenges facing small practices serving minority and limited English proficiency patients

Type of challenge	Examples of challenges mentioned by physicians
Patient adherence with treatment recommendations	''(1) Assuring compliance with medical [treatment] plans, follow-up visits, and preventive screenings. (2) Maintaining open lines of communication for patients. (3) Educating these patients concerning their medical conditions to improve compliance and outcomes.''
Patients' beliefs about their health and health care	''Minority patients remain reluctant to reverse outdated practices and beliefs ie, 'it's okay to have a premature baby'; 'it's okay to skip my appointments or mammograms or meds to take care of other things or people'; 'its okay to treat my diabetes or hypertension by an herbalist alone.'''
Staffing	''I have always liked staff to reflect my largely minority patient base that includes minority physicians and lawyers as well as hotel, restaurant and factory workers. My recent challenge is in maintaining staff that is sensitive to both of these populations and have expected work ethics and even basic job skills.''
Language barriers	''The main challenges faced by my practice in relation to minority patients are multifold especially in treating the adult/elderly persons. A significant number have difficulty in language skills and rely on their children or office staff to translate. Certain embarrassing topics are not discussed due to presence of female staff or children.''
	''Labeling medications at the pharmacy for the specific language of patients [is a problem].''
Lack of information systems	''We cannot track or document minority population care.''
	''We are pretty able to track the ethnicity and language needs of our patients because the predominant need is for Spanish speakers. The problem we face is being able to track the patients by disease state. We can't do this well manually. Because of this, it is difficult to appropriately follow up with patients and be proactive in our communications for our patients with chronic disease.''

minority patients. Other challenges identified via open-ended questions included: staffing and high staff turn over; providing access for limited English proficient patients; addressing varying patient beliefs about health and health care; and patients' low levels of adherence to treatment recommendations (Table 2).

The physicians reported being well-prepared in many areas of caring for diverse patients, with more than two-thirds reporting feeling either well prepared or very well prepared to care for patients who are members of racial/ethnic minorities or whose religious beliefs affect treatment. However, the needs assessments also identified opportunities for improvement related to: (1) caring for diverse patients; and (2) work processes and quality of care (Table 3). In caring for diverse patients, more than one-third of physicians reported concerns in caring for patients with limited English proficiency, new immigrants, or patients from different cultures. More than half of the physicians also felt that identifying cultural customs, accessing specialty care services, and social and environmental challenges were significant problems in their practices. More than one-third reported difficulty in arranging specialty services for their minority patients (frequently because linguistically appropriate care could not be identified) and in getting their prescriptions filled. The majority (17 of 20) reported difficulty providing telephone advice to patients who speak other languages.

Regarding work processes and quality of care, many physicians reported lacking or having inadequate processes in place to support patient access and communication, such as providing telephone triage and advice. More than one-third reported difficulties scheduling and providing same-day appointments or providing telephone advice on clinical issues within a specified time. Of the 19 practices responding to the question, seven had no method for recording patients' preferred language in the medical record, and nine had processes in need of improvement. At least one-third of the practices did not have systems in place for identifying patients in need of follow-up care, such as those due for follow-up visits for chronic conditions. All of these processes reflect systematic challenges within the practices that affect both minority and non-minority patients.

The California chart review asked each physician to assess whether information about race/ethnicity, preferred language, and communication concerns was recorded in each patient's chart. Race/ethnicity data were included in none of the 10 charts for 4 practices, in some charts for 2 practices, and in all charts for 4 practices. Patients' preferred language was included in none of the 10 charts for 3 practices, in some charts for 3 practices, and in all charts for 4 practices. Seven practices had no information on communication concerns for any of the charts they reviewed.

The physicians from California were also asked to think about 2 patients they had recently seen. The first patient was described as ''the last patient you saw from a minority racial or ethnic group where the visit went very well.'' Physicians were asked to describe three things that made the visit work well. Examples cited by the physicians included speaking the same language as the patient and understanding the patients' religious and cultural concerns:

> ''A patient came during Ramadan [a Muslim holiday requiring fasting] with uncontrolled diabetes, and they were very happy I spoke the same language and could explain to them how to eat during this time.''
>
> ''28 [year old] Nigerian female, new patient, very recent immigrant from

Table 3. Areas for potential improvement for physicians and practices

Caring for diverse patients	Work processes and quality of care
More than one-third of the physicians reported feeling less than ''well prepared'' to care for patients …	More than one-third of the physicians report either having no process in place to support patient access and communication, or a system that ''could use improvement'' in these areas:
- with a distrust of the US healthcare system; - with limited English proficiency; - who are new immigrants; or - who use alternative or complementary medicines.	- scheduling patients with a personal clinician; - determining through triage how soon a patient needs to be seen; - maintaining the capacity to schedule patients the same day they call; - scheduling same-day appointments based on the practice's triage of patient conditions; - scheduling same-day appointments based on patient request; - providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time; and - identifying and prominently displaying in the medical record the - language preferred by the patient.
More than one-third of the physicians reported feeling less than ''very skillful'' in delivering care to patients from different cultures than their own in the areas of: - assessing the patient's understanding of the cause of his or her illness; - identifying whether a patient is mistrustful of the healthcare system or the physician; - identifying religious beliefs that might affect clinical care; - identifying cultural (non-religious) customs that might affect clinical care; - identifying how a patient makes decisions with other family members.	More than one-third of physicians report not having a system to generate reports to identify patients who need follow-up care in the following areas: - patients who need pre-visit planning, such as obtaining tests prior to the visit; - patients who need their records reviewed by a clinician (reasons may include missed visits or abnormal test results); - patients on a particular medication; - patients who are due for preventive care; - patients who are due for specific tests; and - patients who are due for follow-up visits such as for a chronic condition.
More than one-third of the physicians reported feeling that certain aspects of caring for racial and ethnic minority patients were a ''big problem'' or ''somewhat of a problem.'' These areas included: - providing telephone advice to patients who speak other languages; - their ability to help patients access specialty care services; - patients' ability to get prescriptions filled; and - social and environmental challenges that prevent patients from adhering to physician recommendations.	

These data were collected as part of the needs evaluation conducted at the beginning of the project. The questions related to caring for diverse patients were drawn from Weissman et al.[10] The questions on work processes and quality of care were drawn from NCQA's Physician Practice Connections Readiness Survey.[9]

> prior residence in rural Nigeria, very anxious about first office visit ever. … Was able to understand her deep concern and urgency about suspected infertility (a major cultural and marital problem for most African women who are expected to bear children).''

The second patient the physicians were asked to consider was ''the last patient you saw from a minority racial or ethnic group where the visit did not go well for reasons related to the patient's race, ethnicity, or language.'' When asked to describe factors contributing to the difficult nature of the visit, physicians cited a number of examples, including patient lack of understanding of the US healthcare system, accusations of racism, and the inability to locate specialists who could provide care in the patient's language.

> ''They expected they could all be treated by the doctor at this one visit for one [patient].''
>
> ''Her insurance requires certain steps prior to getting care so we couldn't right away give her the medication. [Patient] had trouble understanding why and cooperating. Her friend called saying, 'if this was a white patient …'''
>
> ''[The patient was] only Spanish speaking … I was unable to locate a Spanish-speaking psychiatrist despite numerous time-consuming phone calls … I was told to send her to the [emergency room] where she could get 'suicide care through an interpreter.' Despite having very good private insurance, ultimately I had to transfer this patient to a county facility … so that she could receive culturally and linguistically competent care.''

Our needs assessment identified significant challenges in a number of areas. Some of these, such as tracking and managing patient information, would make it difficult to implement quality improvement efforts regardless of patients' race/ethnicity. Others, however, will impact only racial/ethnic minority patients, such as problems in identifying patients' cultural customs that may affect their health, having

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difficulty arranging linguistically-appropriate specialty care, and difficulties providing telephone advice to patients who speak languages that the physician does not.

DISCUSSION

Small primary care practices face significant challenges in caring for minority patients. While many of these challenges are also faced by larger practices, they disproportionately affect small practices and are likely to hamper wide-scale efforts to improve quality and reduce disparities in small practices. This particularly includes the lack of electronic information systems and electronic health records for tracking information such as race/ethnicity and language, as well as care coordination and patient clinical characteristics.[11]

At the same time, the needs assessment illustrates some of the challenges that are inherent in working with patients who may have cultural- or religious-specific concerns and those whose preferred language may not be English. Since small practices have fewer staff members, they may be less able than larger group practices (employing physicians and staff with a variety of cultural backgrounds and language skills) to meet patients' specific needs in these areas. In addition, the examples described show some of the challenges faced by primary care providers regarding language, the use of interpreters and bilingual staff, access to culturally and linguistically appropriate specialty services, patients' understanding of how the US health care system works, and patients' concerns about bias and discrimination. A lack of ability to address many of these issues may be exacerbated in a small practice setting with limited staff and resources.

Our study has a number of limitations. In particular, this was a small sample of practices that agreed to participate in a hands-on quality improvement project designed to improve care for minority racial/ethnic patients. It is possible that those practices that enrolled in the program were those that perceived greater difficulties in this area, or a greater need for assistance in improvement. Similarly, since the project included only practices in New Jersey and California, we cannot assess the extent to which our findings are generalizable to other geographic areas. At the same time, however, little has been known to date about small practices' strengths and challenges, and this work represents a first step toward understanding their needs.

If we are to make progress nationally toward reducing racial and ethnic disparities in care, it is imperative that small practices be specifically included in efforts to improve the quality of care for minority patients. Given the prevalence of visits to small physicians' offices, their contributions in this area will be essential. Small practices face considerable challenges in caring for patients from different racial/ethnic, cultural, and linguistic backgrounds, and have limited resources for making improvements on their own. These practices may also be significantly disadvantaged if they disproportionately provide care to minority patients. One study noted that primary care physicians whose practices include large proportions of patients who are African American or Latino report that they see more patients, depend more heavily on Medicaid revenues, provide more charity care, and earn lower incomes than those physicians who see mostly White patients.[12]

Newer public policy changes are designed to increase the use of electronic health records and encourage the development of patient-centered medical homes, both of which pose significant challenges for small practices.[13,14] Given the challenges described here, significant support from national, regional, and local organizations will be required to ensure that such quality improvement efforts can be implemented in small practices, and that these practices are able to contribute to reductions in racial/ethnic disparities.

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AUTHOR CONTRIBUTIONS

Design concept of study: Weinick, Byron, Han, Hudson Scholle
Acquisition of data: Byron, Han, Briefer French, Hudson Scholle
Data analysis and interpretation: Weinick, Byron, Han, Briefer French, Hudson Scholle
Manuscript draft: Weinick, Byron, Han, Briefer French, Hudson Scholle
Acquisition of funding: Briefer French, Hudson Scholle
Administrative, technical, or material assistance: Byron, Han, Briefer French, Hudson Scholle
Supervision: Weinick, Han, Hudson Scholle