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

ESSENTIAL HEALTH CARE PROVIDERS FOR OUR COMMUNITIES

Executive Summary and Recommendations

November 2012

By

Ignatius Bau and Ho Luong Tran, MD, MPH

with assistance from

Barbara Cardinal, David Hawks, Kim Tran, and Grace Yoo, PhD

EXECUTIVE SUMMARY

In this report, the National Council of Asian Pacific Islander Physicians (NCAPIP) documents the important role of Asian American[1] physicians in solo and small group primary care practices in providing health care to Asian American, Native Hawaiian, and Pacific Islander (AANHPI) patients and communities.[2] The conclusions and twelve recommendations were drawn from pre-focus group surveys, focus group discussions held between November 2011 and May 2012, and post-focus group evaluations. Seven focus groups were conducted in Honolulu, San Francisco, San Jose, Chicago, Houston, Dallas, and New York, with a total of 73 physicians, 54 primary care physicians and 19 of other specialties.[3]

Physicians who participated in the surveys and focus groups described their practices and the challenges encountered by their patients, particularly Asian Americans, Native Hawaiians, and Pacific Islanders, when accessing health care and navigating today's health care systems. They discussed the impact of changes in health care public policies and in their medical practices, including the adoption of electronic health records, patient-centered medical homes, accountable care organizations, and the implementation of the Patient Protection and Affordable Care Act (ACA). They expressed concern about the sustainability of community-based, accessible, and culturally and linguistically appropriate practices. With the June 28, 2012 decision of the U.S. Supreme Court upholding the constitutionality of the ACA,[4] perspectives from these physicians become even more relevant and timely.

The themes that emerged pointed to a strong commitment of the primary care physicians to their patients while feeling under-valued and overwhelmed by the many changes in health care delivery and payment; a resistance to more government regulations that impact and increase demands on their practices; and a desire for clear statements of reasonable and achievable expectations from payers and policymakers.

Pre-focus group survey responses showed clear evidence that the responding primary care physicians were a vital part of the health care provider safety net with 88 percent of them serving uninsured patients on a self-pay basis, 64 percent providing care to the uninsured without charge or on a charity basis, and 69 percent treating patients covered by Medicaid or the Children's Health Insurance Programs. More than half speak a language in addition to English when seeing patients, two-thirds have clinical and administrative staffs that speak languages in addition to English. These additional language proficiencies are vital to ensuring effective communication with AANHPI and other patients who speak primary languages other than English.

---

[1] The project was unable to recruit Native Hawaiian or Pacific Islander physicians to participate in the focus groups. There remains a significant shortage of Native Hawaiian, and Pacific Islander physicians. "Two isle students accepted to UH medical school," *Hawaii 24/7* (June 14, 2012) (while 26 of the population of Hawaii is Native Hawaiian and Pacific Islander, only 3 percent of physicians practicing in Hawaii are Native Hawaiian or Pacific Islander), accessed at: http://www.hawaii247.com/2012/06/14/two-isle-students-accepted-to-uh-medical-school/; Grumbach K, Odom K, Moreno G, Chen E, Vercammen-Grandjean C, Mertz E. *Physician Diversity in California: New Findings from the California Medical Board Survey*, (2008), accessed at: http://futurehealth.ucsf.edu/Content/29/2008-03_MD_Diversity_in_CA_New_Findingsfrom_the_CA_Med_Board_Survey.pdf (significant underrepresentation of Samoan, Cambodian, Lao, and Hmong physicians in California). Accordingly, this report only refers to "Asian American" physicians, so as not to inappropriately generalize findings to Native Hawaiian and Pacific Islander physicians.

[2] Funding for this project was generously provided by the U.S. Department of Health and Human Services Office of Minority Health, through a subcontract under a cooperative agreement with the Association of Asian Pacific Community Health Organizations.

[3] 68 of the 73 participating physicians were Asian American. The other five were White physicians who provided health care to a significant percentage of Asian American, Native Hawaiian, and Pacific Islander patients.

[4] *National Federation of Independent Business v. Sebelius*, 567 U.S. __ , Slip Opinion No, 11-393 (June 28, 2012), accessed at: http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf

The pre-focus group surveys also provide evidence of opportunities to engage and support these physicians. Over half belonged to a local medical society and to a state medical association. One-third had received technical assistance on quality improvement from their medical group/independent practice association and 17 percent had received such assistance from a health plan.

Pre-focus group surveys also showed that this cohort of primary care physicians were knowledgeable about, and early adopters of, electronic health records (EHRs), with 88 percent currently utilizing an EHR system and 59 percent having adopted one in 2010 or earlier. The most frequently utilized functionalities were to document patient demographic data (including race, ethnicity and primary language) and vital signs, track lab results, create office visit summaries, and prescribe electronically. Almost all (95 percent) had heard about the EHR incentive payments available through the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 75 percent intended to apply for through Medicare or Medicaid. One-third knew of colleagues who had already received their HITECH Act incentive payment and one-third had signed a participation agreement with their Regional Extension Center (REC) for technical assistance. Of the latter group, 3 were "dissatisfied" or "very dissatisfied" with their REC, 8 were "neutral", and only 2 were "satisfied" or "very satisfied."

The focus group discussions highlighted challenges encountered by solo and small group primary care physician practices today. Of the 54 participating primary care physicians, nearly half were solo practitioners and over two-thirds practiced in medical groups of 5 or fewer physicians. Although not uniform across all focus groups, many were knowledgeable and opinionated about changes in the health care policy environment. While pragmatic, or resigned, about the changes in health care policies, most prioritized the care of and relationships with their patients. With regard to the future of small practices in safety-net communities, one participant summarized by saying: "Solo and small group practices need support as soon as possible, or there won't be any left."

In post-focus group evaluations, many appreciated the opportunity to be asked and to be heard, and expressed that the issues discussed were common and of similar concern among other AANHPI primary care physicians in solo and small group practices. They articulated the importance of the need to be more involved in policy decisions that impact their practices and patients.

Thus, while our sampling methodology does not allow the results to be generalized for all Asian American primary care physicians, many common themes were articulated and important lessons were learned about how Asian American primary care physicians might be better recognized, valued, and supported by their patients, communities, payers, and policymakers.

The following are twelve recommendations that emerge:

- Recognize HITECH Act Medicaid-eligible providers as "essential community providers" for "qualified health plans" in state health insurance exchanges;
- Develop and make available standardized, open-source, interoperable EHR solutions;
- Support customization of EHR templates;
- Impose more aggressive requirements for health information exchange;
- Develop and leverage culturally and linguistically appropriate patient-facing functions of EHRs to improve communication and engagement with patients, families, and caregivers;
- Monitor CMS and state implementation of the Medicaid EHR incentive program to maximize participation by solo and small group practice primary care physicians;

- Educate and engage primary care providers about the benefits of medical homes;
- Provide technical assistance to solo and small group primary care practices on health care quality improvement using RECs, Primary Care Extension Centers, Community-Based Collaborative Care Networks, and Community Health Teams;
- Fund independent practice associations, minority physician organizations, and other physician-support entities to provide technical assistance to solo and small group primary care practices on health care quality improvement;
- Support training on quality improvement for clinical and administrative staff in solo and small group primary care physician practices;
- Conduct culturally and linguistically appropriate outreach to impacted communities about health reform; and
- Engage ethnic language media in educating community members about health care reform.

NCAPIP sincerely hopes that this project has lifted up the voices and perspectives of these often overlooked members of our nation's health care safety net, and calls on the federal government, policymakers, and health care payers to heed their recommendations. By including Asian American solo and small group primary care physicians - and the many hundreds of thousands of patients that they serve – in the implementation of health care reform and health care delivery transformation, we are more likely to achieve the "triple aim" of improved patient experiences of care, improved population health, and reduced health care costs that will benefit all Americans.[5]

[5] Berwick DM., Nolan TW, Whittington J. The triple aim: Care, health and cost. *Health Aff* (2008); 27(3):759-769

RECOMMENDATIONS

Based on the data collected through this project, the following are twelve recommendations that emerge from the analyses and findings:

1. Recognize HITECH Act Medicaid-Eligible Providers as "Essential Community Providers" for "Qualified Health Plans" in State Health Insurance Exchanges

Under HITECH Act, Medicaid "eligible providers" may receive up to $63,750 over six years in incentive payments for the meaningful use of certified EHRs. The HITECH Act specifies who qualifies as a Medicaid eligible provider (providers with at least 30 percent Medicaid patients, 20 percent for pediatricians), with each state administering the incentive payments through their - Medicaid programs. Many of these HITECH Act-defined Medicaid eligible providers, those practicing in solo or small medical group practice, also are being prioritized to receive technical assistance from the ONC-funded Regional Extension Centers established in every state.

Given the ongoing identification, outreach to, and engagement of these HITECH Act-defined Medicaid eligible providers in each state, NCAPIP has urged CMS and states to require that "qualified health plans" offered by state health insurance exchanges include these providers in their provider networks as "essential community providers".[6] Since these HITECH Act-defined Medicaid eligible providers are implementing electronic health records and demonstrating meaningful use of those EHRs, these providers also are well-positioned to engage in and report on data collection and quality improvement activities to the qualified health plans, the state health insurance exchanges, and CMS.

2. Develop and Make Available Standardized, Open-Source, Interoperable EHR Solutions

Physicians participating in the focus groups were frustrated at the lack of currently available standardized and interoperable EHR products. As ONC and CMS seek to "incentivize" rather than require standardization, with ONC's certification of hundreds of EHRs, it is challenging for solo and small group primary care physicians to make appropriate choices and take advantage of the full functionality of EHRs. Several suggested that the federal government be more proactive in making available a single, standard EHR, especially since public domain EHRs already exist within the Veterans Administration and the Indian Health Services. One commentator has noted: "…a mandate for the adoption of a national EHR, VistA or otherwise, [may not] be politically feasible. However, there is no reason the [federal] government not actively choose to facilitate the adoption of VistA. Each regional HIT Extension Center currently chooses which EHRs it will support. If, instead, they were all to support the adoption of VistA, organizations would still be free to adopt any EHR they wanted, but might be more likely to give VistA serious consideration despite its suspect status as free software."[7]

3. Support Customization of EHR Templates

Many physicians described their painstaking efforts to customize templates and other workflows in using their EMRs. For solo and small group practice physicians, this customization is a costly

[6] 45 CFR section 156.235(c) defines essential community providers as "providers that serve predominantly low-income, medically underserved individuals." While CMS did not name HITECH Act-defined Medicaid eligible providers in this definition of essential community providers in its final regulations on the state health insurance exchanges, the definition is left up to each state. 77 Fed. Reg.18310 (March 27, 2012).

[7] Saver B. The EHR has no clothes. *Health Affairs Blog* (June 20, 2012), accessed at: http://healthaffairs.org/blog/2012/06/20/the-ehr-has-no-clothes

effort in time and resources. Despite their complaints about the challenges of the HITECH Act, they would be very interested in sharing solutions and developing solutions in collaboration with other colleagues like themselves. For example, every primary care physician should not have to customize a template for optimal care for patients with hypertension or with diabetes. These templates should reflect best practice clinical guidelines, clinical decision support and patient engagement. The ONC, RECs, EHR vendors, and other stakeholders should explore proactive engagement of solo and small group primary care physicians in developing customized templates, and make them open-source, freely available solutions.

4. Impose More Aggressive Requirements for Health Information Exchange

It was noteworthy that many physicians moved beyond their dissatisfaction with their specific EHR system or product to the "big picture" challenge of interoperable EHR systems, and true health information exchange. Many were waiting for interoperability to be available. For example, in a local area with two hospitals that are both used by a primary care physician, only being able to access health information from one hospital is inadequate for optimal functionality of an EHR. One commentator noted: "Clinicians choosing products in order to participate in the Medicare and Medicaid EHR Incentive Programs should not be held hostage to EHRs that reduce their efficiency and strangle innovation. New companies will offer bundled, best-of-breed, interoperable, substitutable technologies – several of which are being developed with ONC funding – that can be optimized for use in health care improvement."[8]

Several physicians urged more aggressive federal government regulation to support or require health information exchange. While ONC and CMS continue to push for interoperability and actualization of health information exchange, there remain significant barriers to robust and routine exchange. They articulated a strong viewpoint that the federal government should prioritize this goal and to push stakeholders such as EHR vendors and state health information exchanges even harder to achieve such health information exchange sooner.

5. Develop and Leverage Culturally and Linguistically Appropriate Patient-Facing Functions of EHRs to Improve Communication and Engagement with Patients, Families, and Caregivers

While there was some discussion about patient-facing functions of EHRs and whether AANHPI patients would be able to utilize these functionalities, this is an issue that merits additional exploration, including engagement of AANHPI patients and health care consumers themselves.[9] Commentators have suggested that these patient-facing, patient-engagement functions are the hidden and underutilized elements of EHRs.[10]

---

[8] Mandl KD, Kohane IS. Escaping the EHR trap – The future of health IT. *New Engl Jour Med.* (2012); 366(24);2240-2242

[9] National Partnership for Women & Families, *Making IT Meaningful: How Consumers Value and Trust Health IT* (2012), accessed at: http://www.nationalpartnership.org/site/DocServer/HIT_Making_IT_Meaningful_National_Partnership_February_2.pdf?docID=9783; Consumer Partnership for eHealth, *The Consumer Platform for Health IT: Advancing Patient and Family Engagement Through Technology* (2011), accessed at: http://www.nationalpartnership.org/site/DocServer/CPeH_Platform_for_Health_IT_Final_5.6.2011.pdf?docID=8661; Consumers Union, *Consumer and Patient Principles for Electronic Health Information Exchange in California* (2010), accessed at: http://www.consumersunion.org/pdf/HIE-Principles-6-10.pdf

[10] Tang PC, Lansky D. The missing link: bridging the patient-provider health information gap. *Health Aff.* (2005);24(5):1290-1295; O'Connor AM, Wennberg JE, Legare F, Llewellyn-Thomas HA, Moulton BW, Sepucha KR, Sodano AG, King JS. Toward the 'tipping point': Decision aids and informed patient choice. *Health Aff* (2007);26(3):716-725; Woolf SH, Chan EC, Harris R, Sheridan SL, Braddock CH 3rd, Kaplan RM, Krist A, O'Connor AM, Tunis S. Promoting informed choice: transforming health care to dispense knowledge for decision making. *Ann Intern Med.* (2005);143(4):293-300; Institute for Healthcare Improvement, *Partnering in Self-Management Support: A Toolkit for Clinicians* (2009), accessed at:

6. Monitor CMS and State Implementation of the Medicaid EHR Incentive Program to Maximize Participation by Solo and Small Group Practice Primary Care Physicians

While there was a high level of knowledge about EHRs among primary care physicians in the focus groups and this cohort as a whole seem to be early adopters of EHRs, they also identified significant barriers to successful EHR adoption. It also seems that the RECs intended to provide technical assistance are underutilized and that the majority of those physicians who have participation agreements with the RECs are neutral or dissatisfied with the services. It will be important to continue to monitor the effectiveness of the RECs and to explore other support to ensure maximum participation of solo and small group primary care physicians in the EHR incentive program, especially among Medicaid providers. One recent commentary noted: *"The data suggest that physicians who care for Medicaid or Medicare patients are currently less likely to use EHRs, which would exacerbate the potential for substandard care for low-income or elderly patients. Medicaid incentives may be particularly critical in order to bolster the use of EHRs by physicians caring for low-income patients....To avoid a two-tier system of care, it will be important to monitor how physicians use these Medicaid incentives and their impact – particularly given the expected expansion of Medicaid enrollment under health reform."*[11]

7. Educate and Engage Primary Care Providers about the Benefits of Medical Homes

There were many discussions but no clear agreement among the primary care physicians in the focus group about the merits of the medical home model. As medical home models continue to be implemented by the federal and state governments and by commercial health plans, solo and small group physicians need to be better informed about and more engaged in the design and implementation of these medical home activities. While there may need to be focused technical assistance and other support for solo and small group primary care practices to become medical homes, explicit attention needs to be focused on this subset of providers because of their unique needs and challenges. As a vital part of the continuum of care and the health care provider safety net, it will be important to ensure that the implementation of medical homes does not further widen the gap in the quality of care between solo and small group physician practices, compared with large, multi-specialty medical groups that are dominating the delivery of health care in the U.S. today.

8. Provide Technical Assistance to Solo and Small Group Primary Care Practices on Health Care Quality Improvement Using Regional Extension Centers, Primary Care Extension Centers, Community-Based Collaborative Care Networks, and Community Health Teams

There are many strategies that could continue to support practice improvement and quality improvement among small group primary care practices.[12] The National Academy for State Health Policy has observed: *"…even if able to afford them, very small practices may not need full-time care coordinators, nutritionists, or behavioral health specialists. States have met this need by providing state or contractor staff who fulfill those functions for multiple practices, facilitating (or requiring) practices to form networks that can pool resources to pay for these services, banding together with other payers to fund teams that support all of the practices in a*

---

http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support_a_toolkit_for_clinicians.pdf

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

[12] Casaliano L, Gilles RR, Shortell SS, Schmittdiel JA, Bodenheimer T, Robinson JC, Rundall T, Oswald N, Schauffler H, Wang MC. External incentives, information technology, and organized processes to improve health care quality for patients with chronic disease. *JAMA*. (2003); 289(4):434-441.

community, and fostering co-location of separately funded behavioral health specialists with primary care practices."[13]

A promising idea is to build upon the current RECs that have been established to support the implementation of EHRs.[14] Commentators have called these shared technical services, in contrast to shared clinical services.[15] Section 5405, as amended by section 10501(f)(2), of the ACA authorized the Agency for Healthcare Quality and Research (AHRQ) to establish a Primary Care Extension Program that would provide support and assistance to primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based therapies and techniques. The program would use Health Extension Agents, who are local, community-based health workers, to facilitate and provide assistance to primary care practices by implementing quality improvement or system redesign, incorporating principles of the patient-centered medical home, providing guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources. This section did not receive specific appropriations for funding. Instead, AHRQ has funded four state extension centers (North Carolina, Pennsylvania, Oklahoma, and New Mexico) as demonstrations for an eventual national program.[16]

Two sections of the ACA could support solo and small group primary care practices in quality improvement. Section 10333 authorizes the creation of Community-Based Collaborative Care Networks, consortia of health care providers with a joint governance structure that provide comprehensive coordinated and integrated health care services for low-income populations. Section 3502 authorizes the creation of Community Health Teams that would provide support necessary for local primary care providers to:

- Coordinate and provide access to high-quality health care services;
- Coordinate and provide access to preventive and health promotion services;
- Provide access to appropriate specialty care and in-patient services;
- Provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;
- Provide access to pharmacist-delivered medication management services;
- Provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;
- Promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;
- Provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plan of patients and coordinate care, such as integrative health care practitioners;
- Collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and
- Establish a coordinated system of early identification and referral for children with

---

[13] Takach M, Gauthier A, Sims-Kastelein K, Kaye N. *Strengthening Primary and Chronic Care: State Innovations to Transform and Link Small Practices*, National Academy for State Health Policy (2010), accessed at: http://www.nashp.org/sites/default/files/state.innovations.to_.transform.link_.small_.practices_0.pdf

[14] Grumbach K, Mold JW. A health care cooperative extension service: transforming primary care and community health. *JAMA*. (2009);301(24):2589-2591

[15] Abrams M, Schor EL, Schoenbaum S. How physician practices could share personnel and resources to support medical homes. *Health Aff.* (2010); 29(6); 1194-1199

[16] IMPaCT (Infrastructure for Maintaining Primary Care Transformation) Cooperative Grants, accessed at: http://www.ahrq.gov/research/impactaw.htm.

developmental or behavioral problems through the use of infolines, HIT and other means

These sections have not been funded nor implemented. As ACA is implemented, a national primary care extension program, community-based collaborative care networks, and community health teams should be fully funded and implemented.[17]

9. Fund Independent Practice Associations, Minority Physician Organizations, and Other Physician-Support Entities to Provide Technical Assistance to Solo and Small Group Primary Care Practices on Health Care Quality Improvement

Physicians in the focus groups highlighted isolation and lack of support while implementing practice improvements and responding to expectations of payers for improved quality. Many are active in their independent practice associations (IPAs) and minority physician organizations, and were receiving technical assistance from these IPAs on the implementation on EHRs[18] and on developing and implementing an ACO. In the pre-focus group survey, respondents identified their health plans and IPAs as sources for technical assistance on quality improvement. Commentators have noted that "*because delivery of shared resources is a local activity, federal investments need to build on the existing infrastructure*."[19] The Center for Health Care Strategies has named these local infrastructure organizations "physician-support entities" and has identified them as trusted local partners for solo and small group practice physicians.[20] Federal and state governments and commercial payers should consider funding these IPAs, minority physician organizations, and other physician-support entities as trusted partners to support practice and quality improvement among solo and small group practices.[21]

10. Support Training on Quality Improvement for Clinical and Administrative Staff in Solo and Small Group Primary Care Physician Practices

Data from pre-focus group surveys reflects the invaluable language concordance of physicians, clinical and administrative staff among many of the Asian American solo and small group primary care physicians. While the roles of clinical and administrative staff were not discussed (except for the need to train the clinical and administrative staff in using EHRs), supporting these staff directly is another potential way to support practice and quality improvement in these solo and small group practices. The 2007 CMA Foundation study observed: *"In both the physician focus groups and office assessments, physicians cited concerns about the technical skill level of their staff and their very diverse patients. Strengthening the office staff and their roles as part of the patient care team is a necessary undertaking for small practices when considering approaches to improving both patient satisfaction and quality of care. Training office staff in the team approach to patient care will be even more critical as compensation takes*

---

[17] Grumbach K, Mold JW. A health care cooperative extension service: transforming primary care and community health. *JAMA*. (2009);301(24):2589-2591

[18] Hasselman D. Supporting Meaningful Use in Small Medicaid Practices, *Center for Health Care Strategies Technical Assistance Brief* (2010), accessed at: http://www.chcs.org/usr_doc/Supporting_Meaningful_Use_Brief.pdf

[19] Abrams M, Schor EL, Schoenbaum S. How physician practices could share personnel and resources to support medical homes. *Health Aff.* (2010); 29(6); 1194-1199

[20] Highsmith N. Creating Physician-Support Entities in Medicaid. *Center for Health Care Strategies Policy Brief* (2011), accessed at: http://www.chcs.org/usr_doc/CMWF_Shared_Support_Practices_FINAL.pdf

[21] Highsmith N, Berenson J. Driving Value in Medicaid Primary Care: The Role of Shared Support Networks for Physician Practices, *Center for Health Care Strategies* (2011), accessed at: http://www.chcs.org/usr_doc/Report.pdf; Hasselman D. Practice Transformation in Medicaid: Five Levers to Strengthen Small, "High Volume, High Opportunity" Practices, *Center for Health Care Strategies* (2010), accessed at: http://www.chcs.org/usr_doc/Five_Levers_to_Strengthen_Practices_Brief.pdf

on a greater linkage to the overall management of patient care and improving clinical outcomes."[22]

On quality improvement with solo and small group practices, NCQA noted: *"Small practices often cannot attract or afford specialized staff that larger practices may have. Many staff members in small practices therefore serve in multiple roles, juggling the duties of language interpreter, billing clerk, medical assistant and office manager simultaneously. These staff members can be integral to how the practice functions, and quality cannot be improved without their participation. At the same time, however, they are often stretched too thin and overburdened with administrative tasks. In many practices, there was little or not knowledge of the most effective ways to utilize staff resources to provide the full spectrum of services required by patients, nor the training for existing staff in more effective use of their skills."*[23]

NCQA reported: *"Both physicians and practice staff responded positively to involving non-clinical and other clinical staff in quality improvement training and activities. Staff credited participation in the quality improvement project with improving communication between the doctor and staff and increasing the roles and responsibilities of non-physicians. Physicians reported enhanced enthusiasm and reduced turnover of staff."*

11. Conduct Culturally and Linguistically Appropriate Outreach to Impacted Communities about Health Care Reform

As national health reform moves rapidly toward implementation after the U.S. Supreme Court decision upholding the constitutionality of the ACA, it will be vital to have culturally and linguistically appropriate outreaches to AANHPI - and all - communities. Physicians in the focus groups were knowledgeable about many of the details of the ACA but had concerns about how information about the law would be effectively communicated to their patients. It is critical to use both the provisions in the ACA (authorizing patient navigators and consumer assistance programs[24]) as well as other community outreach and education methods that have been proven effective in reaching diverse communities, including AANHPIs.

12. Engage Ethnic Language Media in Educating Community Members about Health Care Reform

Physicians in the New York focus group noted that Chinese language newspapers had been covering the implementation of national health care reform. Studies have indicated that ethnic language media is an important and trusted source for health information.[25] The physicians also noted that these ethnic media often sought out physicians as experts, columnists, guests, and community spokespersons. There were suggestions that information could be shared with many different media as a way to leverage scarce resources. As national health care reform continues to be implemented, it will be important to continue to proactively engage ethnic media in educating community members. AANHPI physicians can have a vital role as knowledgeable and credible experts to explain the changes to community members. Minority physician

---

[22] Maas E, Blash L, Lee C. *Quality Improvement in Solo and Small Group Practice: Strengthening the Private Practice Safety Net – Lessons for Health Reform*, California Medical Association Foundation (Updated 2009), accessed at http://www.ethnicphysicians.org/projects/QISS%20Final%20Report%20020209.pdf

[23] NCQA, *Supporting Small Practices: Lessons for Health Reform* (2009), accessed at: http://www.ncqa.org/Portals/0/HEDISQM/CLAS/Briefing/Small_Practices_Report.pdf

[24] Community Service Society and Community Catalyst, *Making Health Care Reform Work: State Consumer Assistance Programs (*2010), accessed at: http://www.communitycatalyst.org/doc_store/publications/CAP_report.pdf

[25] Oh KM, Kreps GL, Jun J, Chong E, Ramsey L. Examining the health information-seeking behaviors of Korean Americans. *J Health Commun*. (2012) May 29. [Epub ahead of print]; Woodall ED, Taylor VM, The C, Li L, Acorda E, Tu SP, Yasui Y, Hislop TG. Sources of health information among Chinese immigrants to the Pacific Northwest. *J Cancer Educ.* (2009); 24(4): 334–340.

organizations such as NCAPIP can help develop and disseminate the content of key messages and information that AANHPI community members will need to understand the changes and take full advantage of the coming reforms.

CONCLUSION

NCAPIP is committed to supporting Asian American physicians in solo and small group primary care practices in continuing to provide the highest quality of health care to AANHPI patients and communities. The National Committee for Quality Assurance has noted the importance of small group practices to successful national health care reform: "*Small medical practices play an important role in the care of patients with diverse needs. These practices often have limited infrastructure and face significant barriers to providing the highest quality health care. If small practices are to provide accessible, effective and efficient care for vulnerable patients, they will need additional attention, resources and support. Failure to provide adequate help in adapting to the new demands for health information technology, quality, and accountability could greatly impair the chances for successful health care reform.*"[26]

The data and discussions from Asian American solo and small group primary care physicians obtained through this project reinforce the urgency of that observation. These physicians have a strong individual and collective commitment to serving their communities, especially underserved and vulnerable populations. They are struggling to find support in the rapidly changing environments of health care policy and practice improvement.

NCAPIP hopes that this project has lifted up the voices and perspectives of these often overlooked members of our nation's health care provider safety net, and calls on the federal government, policymakers, and health care payers to heed their recommendations. By including Asian American solo and small group primary care physicians - and the many hundreds of thousands of patients that they serve – in the implementation of health care reform and health care delivery transformation, we are more likely to achieve the "triple aim" of improved patient experiences of care, improved population health, and reduced health care costs.[27]

[26] NCQA, *Supporting Small Practices: Lessons for Health Reform* (2009), accessed at: http://www.ncqa.org/Portals/0/HEDISQM/CLAS/Briefing/Small_Practices_Report.pdf

[27] Berwick DM., Nolan TW, Whittington J. The triple aim: Care, health and cost. *Health Aff* (2008); 27(3):759-769