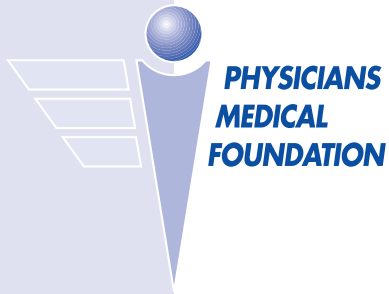

Physicians Retention and Recruitment Study

Alameda, Contra Costa and San Francisco Counties

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Results Summary

October 2005

PMF

PHYSICIANS MEDICAL FOUNDATION

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The Physicians Medical Foundation is a non-profit public benefit corporation supported by a grant from Alta Bates/Summit Medical Center.

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About Physicians Medical Foundation

The Physicians Medical Foundation's (PMF) main purpose is the retention and recruitment of African American physicians, and the betterment of health care for people of color and the underserved communities in the Bay Area.

Our primary goal is to increase the number of practicing African American physicians in Alameda, Contra Costa and San Francisco Counties, while eliminating health disparities and improving the quality of life for patients.

The Physicians Medical Foundation is a non-profit public benefit corporation supported by a grant from Alta Bates/Summit Medical Center.

Mission Statement

Retain and recruit African American physicians to eliminate health disparities, improve access to care, maintain diversity within the profession, thereby, improving the quality of life for people of color in the Bay Area.

This publication was also made possible by a grant from Wells Fargo.

ABOUT THE AUTHORS

Robynn Battle, Ed.D., M.P.H., has years of experience conducting evaluations for community level programs involving adolescent and adult health issues, and programs working within the various communities. As co-principal of CAMI Consulting, Dr. Battle has considerable experience not only in basic social science research but also in the analysis of data. Data analysis work has included both quantitative and qualitative analysis as well as training others on how to review and use their data as a means for program improvement. Additionally, Dr. Battle has authored and co-authored numerous publications on research methodology and community assessments, and HIV/AIDS and women. All her projects have involved a high level of community collaboration and standard research application, allowing her to meet the needs of the community via research methods. Currently, Dr. Battle is an adjunct faculty member at Holy Names University in the School of Education, and works as an associate research scientist with the Pacific Institute of Research and Evaluation in Berkeley, CA.

Gayle Cummings, M.P.H., has years of experience conducting evaluations for community level programs involving adolescent and adult health issues, and programs working within the various communities. As a co-principal of CAMI Consulting, Ms. Cummings has considerable experience not only in basic social science research but also in the development and implementation of prevention programs. Her program work has included strategic planning with an emphasis on community-involvement during the program development phase. Additionally, Ms. Cummings has authored and co-authored numerous publications on research methodology and community assessments, and HIV/AIDS and women. All her projects have involved a high level of community collaboration and standard research application, allowing her to meet the needs of the community via research methods. Currently, Ms. Cummings serves as a faculty member at Touro University in the Department of Health Sciences and works as a program coordinator in the Department of Epidemiology at Marin County Health and Human Services.

Contributor

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Dr. Grumbach also is co-chair of the Research Committee of the Bayview Hunters Point Health and Environmental Assessment Task Force, a community-research partnership, and is a founding member of the California Physicians' Alliance, the California chapter of Physicians for a National Health Program.

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Table of Contents

Page

Executive Summary 3

Part I. Introduction 5

Part II. PMF African American Physicians Registry 7

Part III. Focus Group Summary 18

Part IV. Recommendations 31

Part V. Discussion 37

Appendices 40

- Appendix A – PMF Registry Data Collection Tool 41
- Appendix B – Registry Codebook 42
- Appendix C – Focus Group Questions 46
- Appendix D – Additional Tables 47
- Appendix E - Medical Board of California Loan Repayment Application 50
- Appendix F – County Maps by Specialties 54
  - Alameda County: General Practice Specialties
  - Contra Costa County: General Practice Specialties
  - San Francisco County: General Practice Specialties
  - Alameda County: Additional Specialties
  - Contra Costa County: Additional Specialties
  - San Francisco County: Additional Specialties

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- Gwendolyn Bello

Resources

- Alameda-Contra Costa Medical Association Membership Directory (ACCMA)
- American Medical Association (AMA)
- American Board of Specialties Directory
- California Medical Association Directory
- California Medical Board Directory
- John Hale Medical Society
- Kaiser Permanente
- Local Hospitals, Clinics, Group Practice Directories
- National Medical Association (NMA)
- Student National Medical Association (SNMA)
- San Francisco Medical Society
- Sinkler Miller Medical Association
- Stanford University
- University of California, San Francisco, Department of Family & Community Medicine
- University of California, San Francisco, School of Medicine
- University of California, Berkeley, Joint MS/MD Program

EXECUTIVE SUMMARY

Increasing the number of African American physicians is one strategy that addresses the challenge of health disparities, as recommended by the Institute of Medicine (2004) and endorsed by numerous medical organizations, including the National Medical Association (NMA). As with many communities across the United States, the Oakland-San Francisco Bay Area is faced with the challenge of addressing issues of health disparities, particularly within its underserved communities. To address such inequities within the Bay Area, the Physicians Medical Foundation (PMF) conducted **The African American Retention and Recruitment Study** a comprehensive project, which incorporated the development of a PMF Physician Registry and administration of a series of focus group interviews among African American physicians, fellows, residents and medical students to explore and seek recommendations and strategies around retention and recruitment of African American physicians in Alameda, Contra Costa, and San Francisco counties.

PMF African American Physicians' Registry: After compiling names from various sources, an exhaustive database of 669 African American physicians, residents, fellows, and medical students from across Alameda, Contra Costa and San Francisco counties was generated.

• The database included 53 demographic variables, such as physicians' locale of practice, primary specialty, possession of California medical license, type of practice, and board certification.

• Of the 669 physicians in the database, a total of 480 (72%) physicians in the PMF Registry had "current and renewed" licenses. Of these, 52 (7.5%) were residents.

• Of the 669 names included in the database, 164 were residents, medical students or pre-med students.

• Two-percent (n=10) of physicians were "retired."

• Over half (53%) of the physicians practice/work in Alameda County, followed by almost one-third (26%) --San Francisco County; (14%)-- Contra Costa County.

• Almost half (49%) of the practicing physicians fell under specialties associated with primary care (Family Practice, Internal Medicine, Ob/Gyn, and Pediatrics).

• Internal Medicine was the primary specialty with the largest number of physicians (n=76), followed by Family Practice (n=45), ObGyn (n=39), Pediatrics (n=49), and Psychiatry & Neurology (n=34), respectively.

• Primary specialties with the least number of physicians (3 or less) included: Gastro Preventive Medicine, Addiction Medicine, Infectious Disease, Pathology, Rheumatology, Pain Management and Pulmonology.

• "Group Practices" and "Solo Practices" were the most common practice types.

• When comparing percentages, Contra Costa County had more physicians in a solo practice (21%) than Alameda (12%) and San Francisco counties (11%).

• Thirteen percent of the practicing physicians were affiliated with Kaiser.

• Almost half (46%) of the residents were practicing one of the primary care specialties.

Focus Groups:
A total of seven focus groups and one interview, that included 30 physicians, residents, and medial students and fellows, were conducted over a three month period (November, 2004 through January, 2005). Physicians and residents were randomly selected and stratified to ensure a representative sample across the three counties, physician specialties and practice types, gender and ages. Focus group responses were aggregated across all focus groups and major findings and themes were synthesized by focus group question. Content analysis of focus group results found:

• Most physicians remained in the Bay Area after completing their residency training, and stayed because of their affinity for the area.

• Several physicians' practice experiences were similar, with most finding their work environments supportive. Though generally supportive, racial issues proved to be a challenge for many participants.

• The most common challenge and/or barrier was the high cost of living in the Bay Area. It was felt that this factor coupled with the challenges of working within in a managed care system, made it difficult to practice in the Bay Area.

• Loneliness and lack of diversity were two prominent themes discussed as major concerns for African American medical students in the Bay Area.

• The shortage of African American primary care physicians was widely discussed and viewed as a major problem in the Oakland-San Francisco Bay Area.

• Several were interested in learning more about better business practices, particularly in a managed care environment.

• Financial incentives were identified as the main strategies for successfully retaining and recruiting African American physicians to the Bay Area.

• In addition to financial incentives, mentorship/ preceptorship and social networking opportunities were widely discussed as key strategies to retain and recruit African American physicians to the Oakland-San Francisco Bay Area.

Recommendations:
The primary recommendation is for the PMF Board to devise three subcommittees to address three retention and recruitment components based upon a policy intervention conception model from Grumbach, Coffman and Mertz, 1999. The model components include practice environment strategies, medical education strategies, and applicant pool strategies. Specific program development strategies are recommended within each model component. Secondly, three key recommendations are presented which encourage continuous management and utilization of the PMF Physicians' Registry. Finally, it is recommended that PMF position themselves as a "resource entity" for recruitment and retention of African American physicians, residents and medical students in the Bay Area.

Part I.

INTRODUCTION

Health disparities among African Americans are enormous in scope. Nationwide, African Americans have the highest rates of mortality from cardiovascular disease (heart attack), cerebrovascular disease (stroke), cancers of the lung, prostate, stomach, esophagus and larynx, and numerous other chronic and genetic diseases (American Cancer Society, 2004). Additionally, African Americans have the highest rates of diabetes, obesity, HIV/AIDS, asthma, infant mortality, and low birth weights, for example. The disproportionate disease incidence coupled with the evidence that African Americans receive inferior healthcare compared to Whites, contributes to misdiagnosis, improper treatment, greater disease and premature death illustrate the complexity of the health status of African Americans. (Institute of Medicine, 2004) This report and other numerous medical studies suggest that there are many causes for unequal treatment, including: the paucity of minority physicians, inadequate insurance coverage, and racial stereotyping and bias.

Increasing the number of African American physicians is one strategy that addresses the escalating challenge of health disparities, as recommended by the Institute of Medicine (2004), and endorsed by numerous medical organizations, including the National Medical Association (NMA). Presently, African American physicians make up only 3.9% of physicians nationally - - an increase of only 0.4% from 1960 (NMA, 2005). At the state level, African-Americans account for 7% of California's population but only 3% of physicians (United States Census, 2000; Grumbach,1998). Increasing the numbers of African American physicians is critical for several reasons:

- Evidence has shown that African American physicians tend to work in underserved communities where the need is greatest and thereby increases access to care;
- African Americans and other people of color tend to report greater satisfaction under the care and treatment of physicians who share a cultural understanding;
- African Americans and other physicians of color can help health systems in efforts to reduce cultural and linguistic barriers; and
- Diversity in higher education and health professions training settings is associated with better outcomes among all students. (Institute of Medicine, 2004)

To address such inequities within the Bay Area, the Physicians Medical Foundation (PMF) of Oakland, CA was founded in October, 2002 as the result of a grant from the Sutter Corporation, focused on maintaining diversity among practicing physicians in the Oakland-San Francisco Bay Area. Consequently, the mission of PMF is to retain and recruit African American physicians to the Oakland-San Francisco Bay Area in order to eliminate health disparities and improve access to care, thereby improving the quality of life for African Americans and people of color in underserved communities of Alameda, Contra Costa, and San Francisco counties.

To meet this challenge, PMF conducted **The African American Retention and Recruitment Study** a comprehensive project, which incorporated two levels of data collection:

1) A compilation of all African American physicians, residents, fellows and medical students in the Oakland-San Francisco Bay Area to form

the PMF African American Physicians' Registry Database; and

2) administration of a series of focus group interviews among African American physicians, residents, fellows and medical students to explore and seek recommendations and strategies around recruitment and retention of African American physicians in Alameda, Contra Costa, and San Francisco counties.

The purpose of the PMF Physicians' Registry is to serve as a published document, made available to medical institutions, practicing physicians, health care agencies and the general public. The Registry is the first comprehensive database of African American physicians ever developed for the Oakland-San Francisco Bay Area. Though there have been numerous organizational databases with membership information, PMF's Registry was intended to be exhaustive and include African American physicians and residents across specialty areas, practice types, employment sites, and geographical areas.

The main goals of the focus group interviews were to:

1) Provide in-depth insight into some of the issues regarding the retention and recruitment of African American physicians, residents and medical students in the Oakland-San Francisco Bay Area;

2) Define the professional, business, and personal needs faced by such medical professionals; and

3) Present information that will help in the development of PMF programs aimed at the retention and recruitment of African American physicians, residents, and medical students in the Oakland/San Francisco Bay Area.

Study Protocol

To compile a listing of African American physicians, residents, medical students and fellows and implement a focus group study among a sample of this population, PMF retained the services of CAMI Consulting. CAMI Consulting worked closely with PMF's Executive Director and Board and Kevin Grumbach, M.D. of University of California (UC) San Francisco to develop the protocols for both data collection areas and design data collection tools. CAMI Consulting conducted focus groups independently and provided an overall assessment of findings.

The following sections present the methods used for each component of the study, component findings and recommendations for PMF.

Part II.

PMF AFRICAN AMERICAN PHYSICIANS REGISTRY

Methods

To begin compiling an exhaustive database of African American physicians and residents, data from the following resources were used as a foundation:

- Alameda-Contra Costa Medical Association Membership Directory
- American Medical Association
- American Board of Specialties Directory
- California Medical Association Directory
- California Medical Board Directory
- Local Hospitals, Clinics, Group Practice Directories
- John Hale Medical Society
- National Medical Association
- Student National Medical Association
- San Francisco Medical Society
- Sinkler Miller Medical Society
- University of California, San Francisco, School of Medicine
- University of California, Berkeley, Joint MS/MD Program
- Stanford, School of Medicine

To ensure the most comprehensive list, key individuals at additional organizations and health groups were identified to assist in gathering listings of the names of their African American physicians, medical students, residents and fellows. These included organizations such as Kaiser Permanente, community health clinics, Veteran's Administration hospitals, and county health departments. Names of medical students and fellows were compiled utilizing membership information for the Student National Medical Association (SNMA) and listing of African American students enrolled in medical schools throughout California.

Information collected included: physician names, contact information, primary, California Medial License number, Board of Certification, and medical school.

Once the names were collected, a database in SPSS was created to keep track of all the names and information collected. Excluding names, 71 variables were used to record Registry information. After review, the list of variables were reduced to 53 variables. A list of the variables and values may be found in Appendix B.

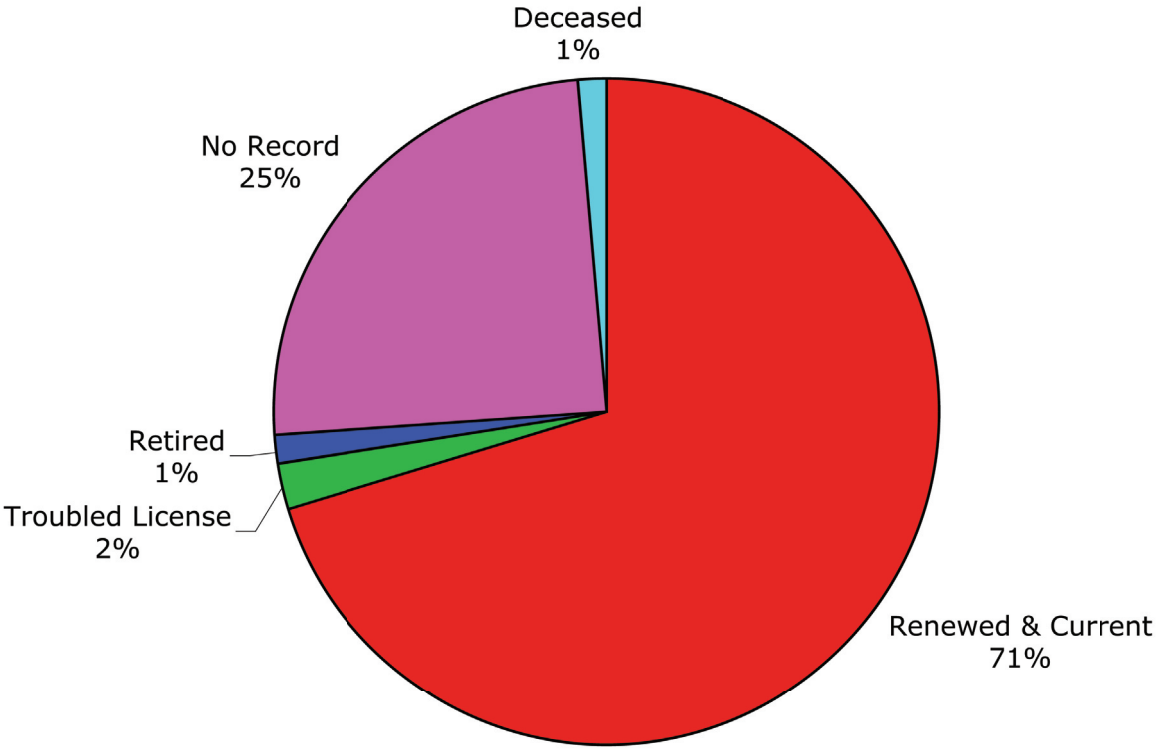
After an initial database was compiled, a short survey (Appendix A) was administered by mail to all individuals in the database. The primary purpose of the survey was to verify the accuracy of the database and was intended to update addresses, account for individuals who had retired or who had died, and provide any additional information regarding changes in medical practice.

REGISTRY DATABASE

The PMF Physicians' Registry currently contains 669 names of African American physicians, residents, fellows, and medical students in Alameda, Contra Costa, San Francisco counties in addition to a small percentage from San Mateo, Santa Clara and Solano counties.

1. **Practicing Physicians & Licenses**. All names within the Registry were cross-checked with the California Medical Board Directory to determine if the person had a current California medical license. Findings from the license review found:

Figure 1. Distribution of Medical Licenses: 669 Physicians, Residents, Fellows & Students



- **Current and Renewed:**
  480 Physicians and Residents
  - A total of 470 (70%) physicians and residents and 10 (1.5%) retired physicians had "current and renewed" licenses.
  - Of the 480 practicing and retired physicians, 52 were residents.

- **Retired:**
  10 Physicians
  - A small percentage (1.5%) of the physicians in the Registry were retired, however, still performed medically related work at administrative level or as volunteer providers.

- **No Record of a License:**
  55 Non-Training Physicians,
  43 Residents & 67 Students
  - A total of 165 (25%) physicians, residents and students had no record of a medical license with the California Medical Board Directory.
  - Of the 165, 55 (8%) physicians had no record of a medical license.
  - Of the 165 non-license holders, 43 (6%) were residents (see Appendix D – Table A for complete breakdown). However, California does not require residents to obtain their license until the conclusion of their second year of residency training; thus, the 43 residents may represent those in their first or second year of training. Additionally, some residency programs and the California Medical Board Directory may not be updated with medical license information, and may not have accurate data available.
  - Of the 165, 67 (10%) were students, who are not yet eligible for medical licensure.

- **Troubled Licenses:**
  15 Physicians and 1 Resident
  - Two percent (15 physicians and one resident) had either "surrendered," "cancelled," "suspended," or "delinquent," licenses or required "continued education" or were waiting for renewal notice.

- **Deceased:**
  9 Physicians
  - An additional 1% (n=9) were recorded as "deceased."

REGISTRY FINDINGS

For the purposes of this report, PMF Registry findings for the practicing physicians (including retired), non-resident/medical students were based on those with "current and renewed" California medical licenses (428 physicians).

2. **Residents and Medical Students.** A sub-group of the Registry were the residents and medical students (n=164). The group was made up of African American students from medical schools throughout northern California as well as a few from southern California. Residents and students distribution was:

3. **Accuracy of Registry Information.** Data in the PMF Registry was compiled from various sources and through contact with physicians and medical organizations affiliated with PMF. Additionally, a survey was mailed out to all contacts in the Registry with an office address. When unopened survey packets were returned by the U.S. Postal Service, alternative addresses were used. Results of both mailings resulted in a return of 134 surveys. Of those returned, 75% of the information matched the individual's Registry information, suggesting that information in the database is fairly accurate. It should be noted that all addresses were cross-checked with the daily updated California Medical Board directory.

Residents	N
• Alameda Co. Medical Ctr.	9
• Children's Hosp. Oakland	7
• Kaiser	5
• Stanford	22
• UCLA	1
• UCSF	31
• Unknown Origin =	9
Total Residents	84

Medical Students	N
• UCSF	45
• Stanford	12
• UC Davis	8
• UC Irvine	3
• UCLA	5
• USC	2
• Pre Med	5
Total Medical Students	80

4. Geographic Location of Physicians.
Table 1 includes the distribution of physicians by geographical location.

Table 1. Physicians Geographical Location by County

	N	percent
San Mateo, Santa Clara Counties and other Counties	45	5
Alameda	228	53
Contra Costa	61	14
San Francisco	110	26
Solano	2	<1
Central California Counties	6	1
Total	**428**	

- Over half (53%) of the physicians practice/ work in Alameda County.

- Almost one-third (26%) were from San Francisco County; followed by 14% from Contra Costa County.

- Since the conception of the PMF Registry, four physicians had relocated to California's Central Valley, or other rural area, resulting in 1% (n=6) physicians in the Registry from that area.

- Another small percentage (5%) of the physicians in the Registry practice in San Mateo, Santa Clara, Solano and other counties. "Other" counties included Sacramento and two from Southern California, outside of the Bay Area. These persons participated in Bay Area medical associations, although they practiced outside of the PMF targeted geographical areas.

5. Physicians' Primary Specialties Reported by County.

Table 2 presents a breakdown of specialties among the physicians with renewed and current medical licenses. A total of 30 specialties are represented.

Table 2. Primary Specialities of Physicians

	N	Percent
Undetermined	21	5
Anesthesiology	20	5
Dermatology	11	3
Emergency Med	14	3
Family Practice	45	11
Internal Medicine	76	18
Neurological Surgery	6	1
ObGyn	39	9
Ophthamology	10	2
Orthopaedic Surgery	16	4
Otolaryngology	4	1
Pathology	2	<1
Pediatrics	49	11
Physical Med & Rehab	3	<1
Plastic Surgery	5	1
Preventive Medicine	2	<1
Psychiatry & Neurology	34	8
Radiology	8	2
Surgery	26	6
Thoracic Surgery	5	1
Urology	8	2
Rheumatology	1	<1
Addiction Medicine	2	<1
Gastro	3	1
Pain Management	1	<1
Cardiovascular Disease	5	1
Infectious Disease	2	<1
Oncology	6	1
Cosmestic Surgery	1	<1
Nephrology	1	<1
Pulmonology Med	2	<1
Total	428	100.0

- Almost half (49%) of the practicing physicians were in primary care specialties (Family Practice, Internal Medicine, Obstetrics and Gynecology, and Pediatrics).

- A small percentage (5%) of the physicians listed in the Registry had specialties that could not be determined.

- Internal Medicine was the primary specialty with the largest number of physicians (n=76).

- The specialties Family Practice, Obstetrics and Gynecology (Ob/Gyn) and Pediatrics were also most prevalent (n = 45, 39, and 49 respectively).

- Primary specialties with the least number of physicians (3 or less) included:
  – Gastroenterology (n=3)
  – Physical Medicine and Rehabilitation (n=3)
  – Addiction Medicine (n=2)
  – Infectious Disease (n=2)
  – Pathology (n=2)
  – Preventive Medicine (n=2)
  – Cosmetic Surgery (n=1)
  – Nephrology (n=1)
  – Pain Management (n=1)
  – Pulmonology (n=1)
  – Rheumatology (n= 1)

- Among the specialties, 35% (n=150) with renewed and current licenses did not report board certification.

6. Physicians' Primary Specialty by County. Figures 2 to 4 provide a visual distribution of the four primary specialties (Family Practice, Internal Medicine, Ob/Gyn and Pediatrics) by county. A detailed table can be found in Appendix D (Table B) of primary specialties by counties.

Figure 2. Alameda County
Main Specialties = 127 of 228 Physicians

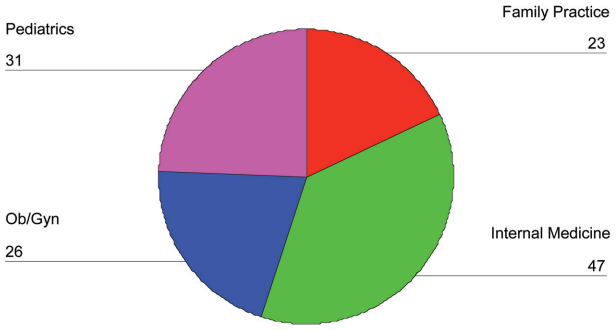


Figure 2. Contra Costa County
Main Specialties = 36 of 61 Physicians

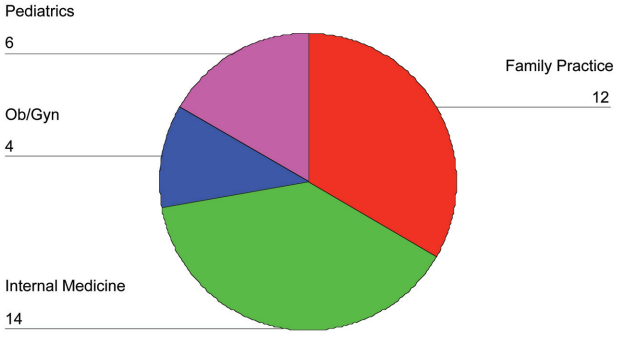
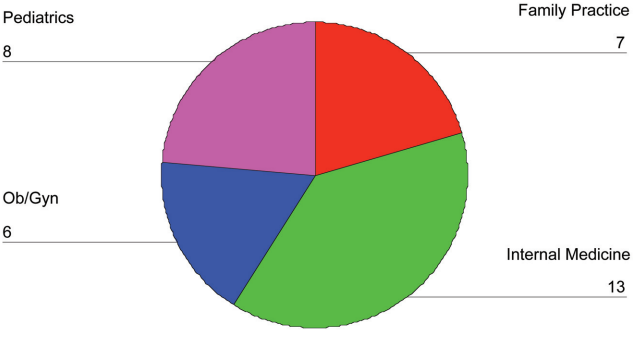


Figure 4. San Francisco County
Main Specialties = 34 of 110 Physicians



- **Comparisons of Family Practice, Internal Medicine, Ob/Gyn and Pediatrics by County.**

  - When comparing specialties across Alameda, Contra Costa and San Francisco counties, it was found that primary care specialties were practiced by 50% of Alameda County's African American physicians.

  - Similar to Alameda County, 59% of Contra Costa county's African American physicians practiced one of the four primary care specialties.

  - Almost one-third (31%) of San Francisco county's African American physicians practiced one of the four primary care specialties.

  - When comparing within specialties, Contra Costa and San Francisco counties had more family

practice physicians (20%, each respectively) compared to Alameda (10%).

- Alameda and Contra Costa counties had almost twice as many Internal Medicine practitioners as San Francisco (21% and 23% compared to 12%).

• INDIVIDUAL COUNTY INFORMATION.

- Alameda County.

- With the exceptions of Addiction Medicine, Pain Management, and Oncology, all specialties are represented by at least one physician.
- The most common specialty in Alameda was Internal Medicine (n=47) followed by Pediatrics (n=31).
- Analysis of practice addresses found that 36% (n=134) of Alameda County's African American physicians' practices were based in Oakland. Other cities with a moderate concentration of African American physicians were Berkeley (n=18) and Hayward (n=15). Of the Hayward physicians, 9 were affiliated with Kaiser.

- Contra Costa County.

- Twelve areas of primary specialty are not represented in Contra Costa County, which include:

- Neurosurgery
- Otolaryngology
- Pathology
- Physical Medicine & Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Radiology
- Rheumatology
- Addiction Medicine
- Gastroenterology
- Infectious Disease

- Analysis of practice addresses found that only 24% (n=14) of Contra Costa County's African American physicians' practices were based in Richmond, where most of the county's African American population is located. Of the Richmond physicians, 8 were affiliated with Kaiser.
- Oakland remained the city with the highest concentration of African American physicians. Other cities with a moderate concentration of African American physicians were Martinez (n=12) and Walnut Creek (n=10).

- San Francisco County.

- With the exceptions of Preventive Medicine, Rheumatology, Gastroenterology, Pain Management, all specialties are represented by at least one physician.
- Only one of the 110 San Francisco physicians was affiliated with Kaiser.

7. Current Place of Practice/Employment.
Table 3 shows the types of practices found among PMF Registry physicians in the database. A detailed table displaying practice type by counties can be found in Appendix D (Table C).

Table 3. Type of Employment

	N	Percent
Self-Employed Solo Practice	66	15
Two Physician Practice	10	2
Other Patient Care	4	1
Locum Tenens	1	<1
Group Practice	91	21
HMO	55	13
Medical School	10	2
Non-Governmental Hospital	29	7
City/County/State Hospital	34	8
City/County/State Clinic	18	4
City/County/State Non-Hospital	8	2
Veteran Affairs	6	1
Non-Patient Care	5	1
Unclassified	91	21
Total	428	

- Group practice (n=91), followed by the self-employed/solo practice (n=66) and HMO's (n=55) were the most common types of medical practices.
- Hospitals of all types and clinics were the also reported most commonly.
- For several (21%) physicians, type of practice was reported as "Unclassified." Possible scenarios were physicians in transition (either leaving a hospital or practice) or uncertain of practice classification.
- When comparing percentages across counties, Contra Costa County had more physicians in a solo practice (21%) than Alameda (16%) and San Francisco counties (13%).
- Percentages were similar for "Group Practice" for Alameda, Contra Costa and San Francisco counties (23%, 18%, 20% respectively) with Alameda having slightly more physicians in group practice.
- Contra Costa County (23%) had slightly more physicians practicing in an HMO than Alameda (13%) and San Francisco (6%) counties.

8. Kaiser Affiliations.

Table 4 displays the distribution of African American physicians affiliated with Kaiser by county and practice location.

Table 4. Kaiser Permanente Affiliation by County and Practice Location

	N	Percent
Alameda	28	7
Contra Costa	14	3
San Francisco	6	1
Solano	1	0
Central California Counties	1	0
Other = San Mateo, Santa Clara Counties	5	1
Non-Kaiser Permanente	373	87
Total	428	

- A total of 55 (13%) African American physicians were affiliated with Kaiser Permanente across the various counties in the Registry.
- Of the 1,989 Kaiser Permanente physicians practicing across Alameda, Contra Costa and San Francisco counties in six medical centers and six medical office sites, African American physicians made up 3% (n=55) of all Kaiser Permanente physicians.
- Twenty-eight of 55 of the African American physicians affiliated with Kaiser Permanente worked in Alameda County.

9. **Residents and Medical Students**.
Table 5 presents the distribution of medical residents and students.

Table 5. Residents and Medical Students - Place of Study

	N	Percent
UCSF Resident	31	19
Stanford Resident	22	13
ACMC Resident	9	5
UCSF Medical Student	45	27
Stanford Medical Student	12	7
Resident - DK	9	5
Kaiser Resident	5	3
CHO Resident	7	4
UCLA Med Student	5	3
UC IRVINE Med Student	3	2
UCLA Resident	1	1
Undergrad	5	3
UC DAVIS Med Student	8	5
USC Med Student	2	1
Total	164	

- Residents and medical students in the Registry mainly came from Bay Area medical schools and training programs. A small percentage, however, were from Southern California schools.

- Almost half (46%) of the residents were practicing one of the primary care specialties (Family Medicine, Internal Medicine, Pedatrics, Ob/Gyn).

- A majority (47%) of those in-training were either UCSF residents or medical students.

- A small percentage (6%) of those in-training noted that they were residents but did not report affiliated institution.

- Another small percentage (3%) were undergraduate pre-medical students.

- A comparison to the overall number of residents and medical students from all of the training facilities was not conducted given the difficulty in obtaining accurate and comprehensive data. Residency and medical school programs were hesitant and reluctant to divulge the composition at their institution.

Part III.

FOCUS GROUP SUMMARY

Methods

A total of seven focus groups and one interview were conducted over a three month period (November, 2004 through January, 2005). A sample of 30 physicians, residents, and medical students and fellows participated. Physicians and residents were randomly selected and stratified to include a representative sample across the three counties and physician specialties. In an effort to interview at least 20 physicians, they were over-sampled. Students were selected through a "snowball sampling" process with one set of contacts leading to new contacts.

Due to the extremely busy schedules of the selected focus group participants, a multi-faceted approach was utilized for recruitment. The primary recruitment methods for physicians and residents consisted of direct calls and faxed and mailed invitations to office sites. PMF Consultants generally communicated at least initially with medical office assistants of potential participants, who were often key for relaying information about the focus groups. PMF's Board of Directors and Executive Director also worked diligently to recruit participants. For example, in two instances special meetings were organized by the Executive Director to conduct focus groups with Sinkler Miller Medical Association and the John Hale Medical Society members to encourage participation.

Focus Group Protocol

A ten-question protocol was generated to assess perceptions of retention and recruitment of African American physicians in the Oakland-San Francisco Bay Area (Appendix A). The protocol addressed the following substantive areas: individual medical practice experiences in the Bay Area, challenges and barriers to practice medicine in the Bay Area; retention strategies; and recruitment strategies.

Results

Demographics

Thirty (n=30) individuals participated in PMF Focus Groups. Participants included 22 physicians, 3 residents, and 5 medical students. Physician and residents practice sites represented Alameda County (n=14); San Francisco County (n= 8); and Contra Costa County (n=3). Figure 1 highlights physician specialties and sites of practice of focus group participants. Three of the five medical students were enrolled in a the joint UCB/UCSF M.D. and M.P.H. program. The remaining two were enrolled at Stanford University and UCSF.

Figure 1. Physician specialties and sites of practice

Areas of Primary Practice	*Practice/Employment Sites*
• *Pediatrics*	• *Kaiser Permanente*
• *Family Practice*	• *Other Non-Kaiser HMOs*
• *Internal Medicine*	• *City/County/ State Clinics*
• *Psychiatry*	• *City/County/State Hospitals*
• *Dermatology*	• *Private Hospitals*
• *Rheumatology*	• *Individual Practices*
• *Anesthesiology*	• *Group Practices*
• *Neurological Surgery*	• *Veteran Affairs*
• *Orthopedics*	• *Private Industry*
• *Cardiology*	
• *General Surgery*	
• *Research*	

FOCUS GROUP THEMES

Focus group responses were aggregated across all focus groups and major findings and themes were synthesized by focus group question.

1. Why did you choose to practice medicine in the Bay Area?

1.1 Received training in the Bay Area.
The overwhelming majority of physicians and residents indicated that they chose to practice in the Bay Area because they received their training in the area. As a result of their time spent during their professional training and development, many commented about the networks they developed, which led to future practice opportunities. Taking over someone else's practice was one such opportunity that was mentioned by three physicians. All of whom maintained that they had become rooted in the Bay Area as a result of the time spent during their training.

1.2 Attraction to the Bay Area.
Professional reasons aside, most participants described their affinity to the area for the same reasons that most Bay Area residents have, such as: the diverse racial and cultural communities that coexist, the weather and natural beauty, and the progressive political climate, just to mention a few.

1.3 Opportunities for African American physicians in private practice.
A number of physicians who started their practices in the sixties and seventies indicated that during that period, there were fewer barriers to starting a medical practice in the Bay Area, in part due to the politically progressive climate. More African American physicians were encouraged to come to the Bay Area and or continue to practice after their training. Additionally, during that time period, as noted by several physicians, there was more of a sizable African American population in Bay Area cities, such as San Francisco, Richmond and Oakland and African Americans tended to go to African American providers for their healthcare. Because of this reciprocal relationship, there was an available client base for African American physicians. African American medical practices at that time were flourishing which further encouraged African American physicians to seek out opportunities in the area.

1.4 Family/Spousal obligations.
Being close to family members was considered an important factor for some in their decision to practice in the Bay Area. Many of the participants who grew up in the Bay Area discussed the significance of maintaining their roots and family ties in the area where they were raised.

Relocating to the Bay Area as a result of a spouse's opportunity was also noted as a reason for choosing to practice in the Bay Area, particularly when both partners were practicing physicians. At least four of the focus group participants talked about coming to the Bay Area as a result of their spouse's job opportunity. Fortunately, in each situation, the accompanying spouses were able to find positions fairly quickly.

2. In general, what has your medical practice experience been like in the Bay Area?

The primary purpose of this question was to gain insight into the experiences of physicians in their medical practices and determining whether these experiences were unique to the Bay Area. In general, physicians described their experiences as having been fairly positive. Experiences discussed were varied and tended to

depend primarily on the number of years that he had been in practice. Medical students, on the other hand, tended to highlight their challenges.

2.1 Historically supportive environment.

Those who began their medical practices during the sixties and seventies, for example talked a great deal about the supportive environment at that time, particularly for private practices.

> ***"There used to be a Black base here, but there weren't a lot of Black doctors, so our practices really thrived…"***

To further illustrate this point, one focus group participant noted that when he began his practice as a pediatrician during the seventies, he was the only African American private practice pediatrician in the city. Additionally, he noted that during this time period, African American physicians treated about 90% of African Americans. These factors, coupled with the sizable African American community at that time helped his practice to flourish and maintain a *"true presence"* in the African American community.

Furthermore, as mentioned in question #1, African American physicians were actually encouraged to take positions with private practices and within hospitals. There was also a camaraderie among African American physicians that was equivalent to what could be found on the East Coast where there was a high density of Black physicians and patients.

2.2 Race Relations.

Despite the supportive environment during this time period, racism was also thriving within medical practice environments. Case in point, one physician who shared his practice with a White physician described how there used to be "Black days and White days" at their medical office, which basically kept White patients from having to share the waiting room with Black patients. Apparently, this was a practice that took place up until the early 1990s in San Francisco with many physicians.

Many of the junior physicians, particularly those who practiced in hospitals or large HMO groups indicated that their experiences had been generally positive, overall. However, subtle forms of racism from their non-Black colleagues in their work environments was mentioned as an issue that they had to contend with on a regular basis. Physicians also mentioned cases of more blatant forms of racism. For instance, one physician described how their medical group provided housing subsidies to their White colleagues, but not to Black colleagues. The physician, however, also mentioned that the medical group was "very friendly and professional" and her practice received many referrals from her colleagues, as one would expect in a supportive group practice environment. Participants describing racial incidences noted that these issues, while not unique to the Bay Area, were probably considerably less offensive than in other parts of the county.

2.3 Limited networking opportunities.

Limited or lack of networking opportunities was another theme that emerged, more so among the junior physicians, residents and medical students. There was a sense that there were no mechanisms, formal or informal, to facilitate networking opportunities between the established African American medical community and those in training. Many focus group participants commented that existing African American physician groups, such

as the Sinkler Miller Medical Association (local NMA society) and the National Medical Association, have not encouraged opportunities for senior physicians to link with physicians in training. The following comment is an example of this sentiment:

"I went to one Sinkler Miller meeting and didn't feel welcomed. There is no support and I don't see them wanting to tap our resources. The specialty groups and organizations want the young doctors, but not Sinkler Miller and the NMA."

2.4 Medical student life in the Bay Area.

A range of perspectives emerged around medical student life in the Bay Area. The issue of "loneliness" as a Black medical student was widely discussed. Another major theme centered on diversity issues among faculty and the study body population. Students also mentioned they have not been surprised by the "*lack of Black faces*", it has still been frustrating, at least for some. One student expressed his frustration with the following example:

"You're constantly feeling that you need to prove yourself as a Black student to faculty as well as to non-Black students. Even though affirmative action no longer exists, you get the sense that some people still think you've gotten in with special consideration".

Another point of dissatisfaction was the lack of relevant class discussions to race and health, which, as one student noted, was because of the lack of diverse faculty.

"It is a thought provoking program …but frustrating because there isn't a diverse faculty. Discussions are sometimes not sophisticated, due to this lack of diversity. It is difficult to discuss social justice issues with regard to medicine when you're working with faculty who don't see the relationship between race, class, and health disparities".

As a consequence of this reality, it was pointed out that there have been "blaring" faculty mentorship deficiencies.

On the other end of the spectrum, one student noted that there was never an expectation on their part that there would be diversity in medical school.

"That's the reality. I was [pleasantly] surprised to see as many Black faces as I did at UCSF. With that I haven't felt uncomfortable with the situation. I feel that my classmates are aware, involved and sensitive to issues of race. "

Along those lines, there seemed to be a general appreciation of University of California, San Francisco (UCSF) School of Medicine which was noted from UCSF students as well as from students from other local medical schools/programs. There was a sense that UCSF's Medical School was progressive and provided a supportive environment for African American students, *in spite of diversity limitations*.

3. What have been your main challenges/ barriers to practice in the Bay Area? Are these challenges specific to the Bay Area?

The primary purpose of this question was to explore the challenges faced by physicians and physicians in training and to determine whether their experiences were unique to the Bay Area. Responses to this question, across all focus groups indicate that there are tremendous challenges to practicing medicine and training for African Americans. Four main themes emerged.

3.1 Cost of Living.

Passionate discussions about the high cost of living in the Bay Area took place across all focus groups. Clearly, this was an issue of concern for all physicians, but even more so for younger physicians and those recently coming out of training. Every respondent noted the real estate market, which was described by one person as being "out of control and unbelievable."

"Here, even doctors can't afford to live in nice areas".

"It is a huge problem…coming out of training, it's difficult…..people want to have something nice… but on a budget of 500-600K, you have to get a fixer-upper".

Within this context, many pointed out that Bay Area's public schools were rated extremely low according to national averages which required an additional expense of paying for private schools. It was also mentioned that by living in the Bay Area, you also pay more for food, gas, entertainment, wages (if you have employees) and many other expenses. These costs coupled with the often enormous educational debt, have presented a somewhat dim financial outlook, according to several respondents.

The real estate market has had an impact on personal residential property as well as on commercial business property. This, according to many respondents has made the cost of running a private practice an enormous financial barrier. In addition, many respondents indicated the difficulty in hiring qualified office staff at an affordable pay rate or salary. In order for salaries to be on par with the pay scales for Bay Area incomes, physicians have to payout a sizable portion of their office incomes.

3.2 Managed Care.

Related to the cost of commercial business property, a number of respondents noted that starting a private practice has continued to be more difficult over the past few years. Though managed care plans have been around in some form since the beginning of the century, the rise of such health plans did not take place until 1973 when the HMO Act was approved supporting health insurance market competition and attempted to reduce costs by rewarding physicians for cost containment (Smith, 2001). With the steady shift toward most medical provisions made through managed care, several respondents contended that African American physician private practices have been struggling and ultimately diminishing. One such reason, as pointed out by several respondents, is that traditionally, African American private practice doctors cared for a large Medicaid/ Medicare and MediCal recipient base. Now, larger groups are accepting these patients, whereas in the past they were not, for various reasons.

In addition, African American physicians used to treat a large percentage of

African American patients in the general population, but this has changed partly as a result of the African American population being "pulled away" from African American physicians. Part of this "pull" was due to the emergence of managed care groups, which have been difficult for all doctors to be included in, regardless of ethnicity. This competiotion coupled with the decrease in referral base, has made it difficult for several African American physicians. For example, "an African American patient may have preferred to be treated by a doctor who looks like them, but must often go elsewhere, to a larger group that may or may not have a physician that looks like them." (Hood, 2001) This sentiment was expressed by several of the focus group participants.

Moreover, several physicians voiced the following perspective, as summarized by one participant:

"It is extremely difficult to be guaranteed admittance into established medical groups such as Brown & Toland or the Hills Group, for example……. This is a particular problem for younger doctors. It's much easier for them if they just go and work for Kaiser."

Additionally, it was pointed out by a number of respondents that managed care decisions are economically and not racially motivated. "*It is more about the bottom line*", as suggested by one respondent. Further, many doctors believed that managed care required more attention to the business aspect as opposed to actual care of patients. One respondent jokingly noted, "*You need an MBA to run a doctor's office these days.*"

3.3 Fewer Black primary care/ referral doctors. One consequence of managed care as described above, has been the reduction in the number of African American primary care physicians in private practice available to African Americans as well as the general population for primary care. This was a definite concern voiced by a majority of participants, who indicated that a major consequence of managed care was the disproportionate number of African Americans that were forced to rely on hospital emergency rooms for primary care because of decreased access to local culturally competent physicians.

Additionally, the decline of African American primary care physicians in private practice has greatly impacted specialists who depend on these referrals and networking. This sentiment was summarized by one participant with the following observation:

"As time moves on, the Black base is decreasing… you can make a living, but it's difficult because "there are fewer referrals which discourage black doctors to practice here."

Within this context, it was also noted that the hospitals have not been supportive of bringing in Black private practices either. "*Hospitals, [like HMOs] only care about the bottom line*," as observed by one of the participants.

3.4 Lack of mentorship opportunities. The lack of organized mentorship opportunities for residents and junior physicians in

the Bay Area was a theme that surfaced in almost all of the focus groups. One perspective, which was voiced primarily among the residents and younger physicians, maintained that lack of mentorship opportunities was a major dilemma. Whether formal or informal, focus group participants discussed the importance of mentorship programs to connect physicians-in-training with senior physicians. It was suggested that these types of networking situations were critical in providing hands-on guidance regarding practice management, patient care, and personal methods or styles needed for successful medical practices. Furthermore, a great deal of discussion surrounded potential employment opportunities that often emerge out of mentorship programs and exposures.

The following quotes summarize this sentiment:

"I was fortunate….I took over someone's practice who had retired. I learned about it through a mutual friend. The great thing for me was that the practice was in tact…there were already resources, existing HMO contracts…. However, this is a unique situation, one where networking made a difference. I think that mentorship programs and opportunities can have the same kind of end result."

"….being able to gain wisdom and insight from someone who you feel is a role model can make a tremendous difference … you can learn from them and hopefully emulate the things that they do to make their practices work…"

"Looking for mentors is difficult because there are so few. There isn't support in general for African American students."

Conversely, from the perspective of some of the senior physicians in the focus groups who underscored the lack of mentorship opportunities, it also was indicated that mentorship in private practice environments was considered extremely challenging and complicated due to physicians' "lack of time" and the requirements surrounding patient privacy (HIPAA) policies.

4. In terms of serving the underserved populations in Alameda, Contra Costa, and San Francisco Counties, what physicians are in short supply?

4.1 Primary Care Physicians.

The numbers of primary care physicians, particularly in private practice, have been dwindling, as mentioned earlier and again unanimously reported by participants for this question. Primary care physicians are considered the "gatekeepers in the medical community" who play a major role in providing continuing, comprehensive and preventive medical care. Without major interventions, this shortage, as suggested by focus group participants, will only get worse for African American physicians.

"….look…it's much easier for young doctors to go and work for Kaiser and many middle class Black people are going to Kaiser as well…. Why would any primary care physician want to struggle in private practice without a patient base…without being reimbursed properly…..?"

For the most part, respondents were supportive of specialties other than family practice and internal medicine, but felt that a more visible community presence of primary care physicians might encourage more

African Americans to seek out preventive care. It was felt that early preventative visits prevented the occurrence of complications associated with ailments (e.g., diabetes, heart disease, hyper tension) that so heavily impact the African American community and decrease emergency room visits.

It was noted that even with community clinics there was a limited pool of African American primary care physicians. Reasons for this shortage were varied and included the reasons mentioned in Question 3 (i.e. the impact of managed care and the high cost of Bay Area living/real estate). From a different perspective, it was also observed that there is a huge misconception about the lack of financial compensation in working as a primary care physician for a community clinic, which has deterred African American physicians from wanting to work in that kind of environment. This notion was summarized as follows:

"There are misconceptions about working for clinics….that you don't get paid well. This isn't true, you can earn a decent salary with a clinic….. Just because you serve low income people, you don't have to be poor …there are options".

Several physicians noted that in addition to the need for more African American primary care physicians, there was a shortage of African American physicians in all specialties, including sub-specialties in mental health, such as psychiatry and neurology. Within this context, some physicians noted that there has been a dramatic drop in funding for mental health programs in the Bay Area, and as a result there are fewer practicing mental health specialists. This has added another challenge for primary care physicians, as explained by one participant:

"You have to be the patient's de-facto psychologist because there are fewer psychiatrists to refer them to…. I've been in situations where we've been working with a kid who is suicidal…. it took United Health Care 3 hours to agree to a psychiatrist and then figure out where they could go…"

5. Financial incentives is one strategy that has worked with federal programs to recruit physicians to underserved communities. What is your perception of financial incentives as a strategy?

The high cost of living in the Bay Area, coupled with other financial obligations for younger doctors, in particular, such as, medical school loans, has created some unique financial challenges to practice medicine in the Bay Area. Many participants also remarked that practicing medicine is no longer as financially rewarding as it used to be, especially in the Bay Area, where *"you can work for private industry and make ten times as much as a medical doctor with a practice"*, as described by one participant. This sentiment was further expanded on by another participant:

"I've been trying to get another physician in my practice for a long time. Doctors need to be compensated fairly here...People [doctors] in Houston, Atlanta, and other places with large Black populations know that their dollars won't go very far here…"

In response to these challenges, many of the larger medical groups, such as Kaiser Permanente have adopted financial incentives, such as, low interest home loans for down payments and signing bonuses.

5.1 Repayment /Forgivable Loans.

A great deal of discussion focused on federally funded health service programs which were designed to place more primary care physicians in underserved communities in exchange for repayment of student loans. Many felt that programs like this provided that extra piece of financial support which can make a difference to encourage primary care physicians to stay in the area. Unfortunately, these types of programs are currently not as well funded and therefore not as visible, according to some participants. Participants expressed views that these programs mainly targeted the rural as opposed to urban areas.

5.2 Start-up funds for private practice.

Given the enormous financial burden of starting a private practice including leasing or purchasing a site, insurance (medical and business), and administrative support, several focus group participants suggested implementing a mechanism in the Bay Area to direct physicians to low interest loans or funding assistance to establish private practices.

5.3 Business planning in a managed care environment.

Without a doubt, managed care has infiltrated the business of medicine across the country and the Bay Area is a good example of how "*it has dominated our [physician's] focus.*" While the "business of medicine" is the focus in private practice as a result of managed care, many participants commented that their medical training was not sufficient enough in preparing them to work in a managed care environment. Consequently, there was a great deal of conversation in the focus groups around the need for training/educational seminars on the "business of running a private practice". The following remarks sum up the need for physicians' desire to gain a greater understanding in this area:

"There has to be serious education about the realities of running a medical practice."

" It [learning the business aspect of a medical practice] is critical because it is not something that you really learn in medical school."

6. What are your impressions of medical education strategies?

Although this specific question failed to elicit a great deal of discussion, mentorship in some form or another was the primary medical educational strategy discussed throughout the focus groups. (See Questions 3 and 9). In addition, a few of the medical students discussed strategies giving medical students and residents opportunities to work in underserved communities. Despite the positive impact of such programs on underserved communities as well as on physicians-in-training, one participant felt strongly that because of the high turnover of physicians-in-training in programs of this nature, they serve to be potentially detrimental to the communities being served due to lack of continuity.

7. What are your impressions about applicant-pool strategies?

Applicant pool strategies were primarily discussed in terms of high school and undergraduate pipeline or exposure programs in response to the change in admissions policies regarding race at public universities. Focus group participants were able to list a handful of local programs geared toward improving opportunities and exposing students of color to careers in medicine in the Bay Area:

- **FACES for the Future.**
  A three-year internship program which prepares underrepresented minority high school students for careers in health and biomedical professions and assists them in getting into college and training programs.

- **UC Berkeley's Biology Scholar's Program.**
  An undergraduate diversity program in the Berkeley's Department of Molecular and Cell Biology Department, designed to increase the diversity of Berkeley students who success in their biology majors and careers, and ultimately enlarge and diversify the pool of future health science professionals.

- **Health Career Connection.**
  A program for undergraduate students from diverse backgrounds to gain practical exposure, experience and support to pursuer healthcare careers.

According to one respondent, programs at Children's Hospital, Oakland (FACES) and UC Berkeley's Biology Scholars programs, have not only helped to provide exposure but also highlighted the needs of working in underserved communities. Additionally, there was general sense across all focus groups, that these programs did make a difference and should be expanded. Due to the competitive nature of undergraduate and higher education, many participants also suggested that outreach efforts should target younger students at the elementary level, as well.

8. Additional Incentives for Recruiting and Retaining African American Physicians in the Oakland San Francisco Bay Area.

Physicians, residents, and medical students were asked if there were other incentives that they would recommend to recruit and retain African American physicians to the Bay Area. Responses across all focus groups referred back to financial incentives, as previously mentioned. Many felt that issues such as prejudices in the workplace and the challenges created by managed care were universal and not necessarily unique to the Bay Area. The financial challenge or high cost of living in the Bay Area, however, was something unique to the Bay Area, and played a major part in deterring African American physicians from coming to the area or encouraging them to remain. In particular, several respondents reiterated the need for assistance with housing, in the form of forgivable or low interest loan or signing bonuses that included some sort of coverage towards a decent down payment on a home.

9. Additional Strategies for Recruiting and Retaining African American Physicians in the Oakland-San Francisco Bay Area.

The final question asked of focus group participants about additional strategies that could be used to recruit and retain physicians in the Oakland-San Francisco Bay Area. As with the "additional incentive" question, physicians and residents referred to previously mentioned answers, however, several did suggest other specific PMF-directed strategies.

9.1 Networking events.

A large percentage of the physicians, residents and medical students from the focus groups were familiar with the PMF mixer in October 2004 and felt the event was an excellent method for networking between medical students and physicians-in-training with established local physicians in the Bay Area. Though only a few of the physicians who mentioned the strategy were able to attend that particular function, those that did not attend still liked the idea and felt it would be beneficial in the future. Ultimately, there was overwhelming support for seeing more networking functions in the future. All of the residents and students interviewed attended the mixer and found it to be beneficial, as it served to provide a sense of belonging and reassurance, as described by a medical student:

"I was yearning to get some exposure to some African American physicians here, which is why I came."

A sense of belonging and feeling welcomed is critical, given the circumstances that many students and residents find themselves. Within the context of the PMF mixer, this notion was summarized by a resident:

"It feels good to have someone reach out to you to invite you to participate."

To further highlight this sentiment, another resident described how welcomed they felt after being accepted into medical school on the east coast. After their arrival in the city/on the campus, there was a welcoming day, and they were invited to a physician's home for dinner. This was an important welcoming gesture and made a difference on their views of the campus. The PMF mixer was a similar and equally important gesture in their opinion.

Some of the physicians who were retired or close to retiring, liked the idea of the mixer or any other type of event that connected them with younger doctors. For some with individual practices, it was felt that such events would allow them to connect and work with physicians who could potentially take over their practice.

The recommended format of the networking events varied. Some strongly encouraged PMF to continue its mixers and to have them more frequently. Others saw the network as the initial stage of a mentorship process, noting that the network would allow them to take others "under their wings."

Additionally, several physicians noted that the Registry would be a very important component for keeping track of physicians as well as informing those in-training about who was available in their particular primary specialty area. They felt it would play an important part with networking, and keeping all physicians (practicing and in-training) abreast as to who was in the area.

9.2 Mentorship/preceptor-ship programs.

As documented throughout this summary, the lack of mentorship opportunities has proven to be a major challenge. Consequently, many participants suggested that PMF could be instrumental in developing a mechanism for mentorship/preceptor-ship opportunities for physicians in training. A range of perceptions were voiced in terms of

how such programs should materialize. On one hand, some physicians pointed out that since many private practice physicians were often financially strapped and lacked flexibility, perhaps PMF could provide financial incentives/stipends to offset the financial burden which in turn might help to encourage physicians to participate as mentors and preceptors. Conversely, other participants suggested that PMF could simply serve as a resource that identifies physicians interested in being mentors/preceptors. Regardless of the specific nature of the mentorship/preceptor-ship programs, it was unanimously agreed that PMF could take the lead to facilitate the process.

10. Other focus group themes.

Throughout and across all focus groups, there was a natural tendency for discussions to take place outside of the focus group protocol. While some of these discussions were not central to the issues of recruitment and retention, other conversations provided interesting and relevant context to the issues being discussed.

10.1 Black professionals in the 21st century. Among the senior physicians with established practices and those with years of seniority in other medical settings, there was a sense of camaraderie, as clearly observed and passionately discussed in one of the larger focus groups. It was unanimously agreed that African American professionals and doctors, in particular, seemed to depend on one another more, in the years past than today. Though much of this reliance stemmed from the realities of racial segregation and the limited opportunities for African Americans in mainstream society, many noted the positive relationships and support that grew out of these circumstances. Since circumstances have improved, the perspective of younger physicians is that these close ties seem less important, according to some of the senior physicians.

"Now the young people can go to all or any school that they choose…they can make it on their own without the help or guidance that was so important when I was coming up."

"There used to be a time when you'd go to a conference and being that there were only a handful of us there, you'd naturally gravitate to each other... chances are you knew each other or had ties to each other through other contacts or people….These days, you go to a conference and the people don't want to associate with each other. Blacks don't want to be recognized as Black... This is across the board… in business too."

Ultimately, there was a sense of loss and sadness. Many felt that they were responsible for "*paving the way*" for future African American physicians, but there was no appreciation or acknowledgement of their efforts, in their view.

10.2 Black professional community. Another common theme expressed across almost all focus groups centered on the lack of a thriving "Black professional community" or networks. Many compared their experiences to different parts of the country, such as the east coast and some southern cities. According to many, the Bay Area with all of its diversity, lacks the "richness" of Black professional life,

like what's seen in New York or DC, for example. A number of explanations were given as to why the Bay Area is so different, such as:
1). There are fewer African Americans/fewer African American professionals in the Bay Area;
2) Because of suburbanization, African Americans are spread out and do not necessarily live amongst each other, as they tend to in other areas; and
3) There are no social outlets in the Bay Area that target African American professions (i.e. clubs, organizations, etc..).

While some participants seemed to except this limitation as a part of living in the Bay Area, others suggested that with concentrated efforts and energy, a vibrant African American professional community could also exist in this part of Northern California too. Furthermore, focus group participants were encouraged that PMF would play an essential role in these efforts to retain and recruit African American physicians in the Bay Area.

Part IV.

RECOMMENDATIONS

After review and development of the PMF Physician's Registry, discussions with PMF staff and board, and examination of the focus group findings, CAMI Consulting devised key recommendations that focus on actions that PMF can take in order to retain and recruit African American physicians to the Bay Area. Our primary recommendation is for the PMF Board to devise three subcommittees to address three retention and recruitment components based upon a policy intervention conception model from Grumbach, Coffman and Mertz, 1999. The model includes practice environment strategies, medical education strategies, and applicant-pool strategies. Specific program development strategies are recommended within each model component. Secondly, we present three key recommendations around management and utilization of the PMF Registry. Thirdly, we make recommendations pertaining to PMF positioning themselves as a *resource entity* for recruitment and retention of African American physicians, fellows, residents and medical students in the Bay Area. Our final recommendations point to strategies that PMF can take in order to maintain its viability as an organization.

IMPLEMENTATION OF A RETENTION AND RECRUITMENT CONCEPTUAL MODEL

Practice Environment Strategies

To reduce many of the financial and management/ business practice challenges faced by African American physicians in the Bay Area we recommend the following Practice Environment Strategies based upon the focus group results and other relevant research findings.

1) **Continuing Medical/Business Education.** Understanding the "business of medicine" has become central a focus in private practice. Many focus group participants, however, commented that their medical training was not sufficient enough to prepare them for running a medical practice. As a means to encourage and enhance physicians and their staff to use best-practice businesses endeavors, PMF should provide continuous seminars/and workshops on financial planning, medical business planning, budgeting/costing/projections, banking and accounting, retirement and investment, commercial and personal real property, technology information and equipment, state and federal guidelines, staffing & personnel resources and training. Below are three detailed examples of specific trainings/workshops that can be offered:

- **Medical payment reimbursements:** To instruct physicians on how to optimize collections, identify payment trends, and employ front-end activity for error free billing, etc. to help physicians maximize reimbursements from manage care establishments, and state and federal programs.

- **Improving technology information capacity:** To introduce and train physicians on utilizing 21st Century software and hardware to make their practices efficient and competitive.

- **Improving advertising and marketing:** To encourage and explain the importance of advertising in the 21st Century, particularly with the internet. *Note: While compiling the registry database, it was noted that approximately three-quarters of the physicians did not have a website presence.*

In addition, continuing medical education courses for physicians such as pain management, domestic violence, medical ethics, sonograms, mammograms, etc. should be incorporated on a continual basis.

2) **Repayment /Forgivable Loans.**
Currently the majority of federal funding for forgivable loan programs primarily target rural areas as mentioned by many focus group participants. However, the state of California has the California Physicians Corps Loan program that encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their educational loans in exchange for their service in a designated underserved area for a minimum of three years. (Appendix E) Underserved areas are defined as areas with at least 50 percent of the patients from a medically underserved population. PMF may wish **to collaborate or establish a partnership with this program**. If this is not feasible, then PMF should minimally utilize the information as a resource to disseminate to PMF Registry members.

3) **Start-up funds for private practice.**
There are numerous low interest loan programs available, specifically geared toward physician needs intended for private practice start-up funds. Given that several focus group participants commented on the need to develop some type of mechanism in the Bay Area which can help direct physicians to low interest loans or funding assistance to establish private practices, PMF should research available loan programs and provide a resource and recommendation listing. Additionally, PMF should expand their existing relationship with Wells Fargo with the expectation that they might serve as the principal resource for private practice loans for PMF's target group.

Medical Education Strategies

As evidenced from numerous discussions documented in the focus group results, the lack of mentorship opportunities has proven to be a major challenge. Consequently, many participants suggested that PMF could be instrumental in developing a mechanism for mentorship/preceptor-ship opportunities for physicians in training. A range of perceptions were voiced in terms of how such programs should materialize. PMF should act accordingly and implement specific strategies to start developing mentorship opportunities for Bay Area physicians in training.

1) **Continue to Host and Expand the "PMF Networking Mixer".**
The Fall 2004 PMF mixer was well received and attended. Therefore, it is recommended that PMF continue with the event as well as hold it more frequently (quarterly if possible). Several of the focus group participants noted that the event provided them with a chance to connect with others. For medical students and residents, it was a way for them to network with one another as well as practicing physicians; for practicing physicians, the mixer introduced them to future physicians. As part of PMF's efforts to serve as a resource, the mixer serves as a starting point for mentorship (formal or informal) and other activities and programs that PMF can pursue.

2) **Resident and Medical Student Educational Opportunities Mini-Grant.**
As a means for encouraging African American physicians to become interested in working in underserved communities within the Bay Area, we recommend that PMF develop an educational opportunities mini-grant program that encourages up and coming African American medical students and residents on rotation to come to the Bay Area. The purpose of the scholarship would be to help offset the high cost of housing in the Bay Area. PMF can offer

a stipend that covers housing and minimal expenses for one month. Housing will be arranged by PMF who will work with local medical training facilities to accommodate students. The program will target medical students on one-month clerkships and residents on one-month rotations.

3) **Establish Relationships with Local Medical School Admission Offices.**
Given the difficulty in locating and tracking new African American medical students, as evidenced in the development of the PMF Registry, we recommend that PMF initiate a process to establish relationships with local medical school admission offices. By establishing such relationships with key administrators, PMF will likely be able to gain continuous access to African American students as they enter medical school.

Applicant-Pool Strategies

The recent decrease in enrollment of ethnically and racially underrepresented students in medical schools in California and nationwide presents new challenges for the state's ability to train and recruit physicians to serve its neediest populations (Grumbach, et al., 1999). Since schools can no longer directly recruit underrepresented students, applicant pool strategies such as pipeline or exposure programs are essential for African American students, in particular. Below are two examples of applicant pool strategies that can be implemented by PMF.

1) **Build Relationships with Medical Schools' "Pipeline" Programs.**
Both UCSF and Stanford medical schools currently have pipeline programs in place to diversify their applicant pools. Given such strategies pre-exist, it is recommended that PMF attempt to meet with the individuals directing these programs and discuss ways and or the possibility of building a working relationship. Such a relationship provides PMF the opportunity to work with students before they start to leave the Bay Area for other programs in different parts of the state or country. The relationship also gives the program visibility. Though the practicing physician population seems "covered" in terms of outreach, focus group results found that physicians' biggest concerns was making ensuring students were caught early on, even as early as their pre-med stages. Being a co-active "front" with existing pipeline programs allows PMF to maintain a presence with a "hard-to-reach" population if it is to make an impact on its recruiting efforts.

2) **Summer Leadership Camp Academy.**
PMF should implement a Summer Leadership Camp Academy, which consist of a one-week residential, academic enrichment, summer camps that encourages African American junior and senior high school students to become interested in the field of medicine. The purpose of the program would be to expose students to the varied facets of medicine and provide pre-med educational preparation, by introducing junior and senior high schools students to practicing physicians, medical students and business professionals; providing a snapshot of the core business-aspect of medicine; reviewing admission and course requirements for high school, pre-med and medical schools; and offering practical medical utilization skills through role-plays and group activities. There should also be an emphasis on the realities of being a physician (an overview of the different specialties - - potential workloads, various working environments, patient interactions, etc.) Ideally, PMF would work with local medical training facilities, physicians, healthcare and other professionals to implement such a program.

Registry Management and Utilization

An extensive amount of information has been collected on 669 physicians, residents, fellows, and medical students to create the PMF Registry and Database. Given the immensity of the database, it will be important for PMF to devise methods that enable it to manage the data in order to keep it current and readily available for review.

1) **Produce the Registry Bi-annually On-line and Annually in Print.**
   The PMF Registry is the only full list of African American physicians in the Bay Area. Though there are various groups throughout the Bay Area with listings of African American physicians affiliated with individual organizations, none include a comprehensive collection of all names that include the various medical organizations and medical schools.

   Given the uniqueness of the Registry, it's availability to the community is key in promoting PMF's efforts in recruiting and retaining physicians in the area. Availability includes being accessible online as well as in print and as frequently as possible. It is recommended that the Registry be published bi-annually on-line and annually in print. Doing so keeps all interested parties abreast as to who is in the area and where physicians are practicing. Additionally, if PMF is to serve as a community resource, a regularly produced database stresses its commitment to recruiting and retaining physicians.

2) **Continuous Management of the Registry.**
   In order for PMF to keep its' Registry as accurate as possible, it will be important to constantly cross-check physician information with the California Medical Board and other existing databases (e.g. Sinkler Miller Medical Directory, the American Medical Association), the local phonebook and on-line websites. Initial database building efforts and cross-checks found that information for a small percentage of the names provided by the various organizations were dated. Furthermore, after the dated information had been updated, information from mail surveys (completed and returned surveys) showed that data which was accurate three months prior to the mail-out had changed. Continuous management of the database would minimize the number of physicians with dated information.

   To keep the Registry data accurate, it is recommended that PMF hire a person(s) to manage the database and assist in keeping the information current. This person would keep track of those already in the database, as well as work to ensure that any new physicians or physicians who have recently completed their residencies and their practice information are included in the database. Additionally, this person would assist in tracking medical students, a key population to be targeted for recruitment and retention.

3) **Make Registry Available to In-coming Medical Students and New Residents to the Oakland-San Francisco Bay Area.**
   Once PMF builds a relationship with the local medical school admissions offices (see medical education strategy recommendation), it can serve as a resource to all incoming African American students at UC San Francisco, UC Davis and Stanford. Once established, PMF will need to make sure that all students identified receive and continue to receive the Registry. Ensuring that students receive the Registry, serves as a welcome and invitation, and creates a sense of community so many practicing physicians felt was lacking in the Bay Area.

   Serving as a resource, PMF must start to "think" like a medical school and or university, and start to devise programs and activities that actively invite (recruit) physicians in-training to the area and African American medical community. Several practicing physicians from the focus groups noted that the key to recruiting

physicians was actually to retain those already in-training at local hospitals and medical schools. Providing physicians in-training with the Registry serves as a starting point for drawing in future physicians and exposing them to a community that wishes to include them in the future.

PMF as a Resource

As PMF continues to build itself as an entity that retains and recruits physicians, it will be necessary to ensure that its name is affiliated with such efforts and that it is seen as a place where physicians and others can obtain information. In order to make the implementation of the conceptual model, as described above successful, PMF must "brand" its name - - a marketing practice commonly used when an up-and-coming entity is attempting to establish "service" associations with their brand name. The goal of PMF is to ensure that its name is associated with being a "one-stop" shop for up-and-coming, practicing and retired African American physicians. The following two recommendations can help in "branding" the PMF name.

1) **PMF should develop marketing tactics/ strategies in order to make itself and its mission known to the "community" (i.e., medical community, public health community, general community).** Currently, PMF has two key elements needed for building a foundation for the organization and its' efforts towards physician recruitment and retention: the PMF Registry and the PMF Networking Mixer. Both provide the organization with the "tools" needed to develop additional activities and programs that assist PMF in addressing the organization's mission. PMF's next step, however, is to devise a "marketing" plan, one that would make its mission and future services known to the public. Taking such steps, enables PMF to build a name for itself, which in turn, helps to generate funds for future programs.
A marketing plan also helps PMF to clearly define its purpose, which in turn drives the programs and activities implemented by PMF. All too often, newly created organizations struggle with the development of programs that "fit" their agency. As the marketing plan is developed, PMF is given the chance to go through a strategic planning process that allows the organization to revisit its purpose and assess and market the organization's vision - - to recruit and retain African American physicians.

2) **PMF should make itself available as an organization that is seen as a resource for doctors, residents and medical students.** Similar to the previous recommendation, PMF should take steps to establish itself within the medical community as a resource center. PMF could work to bring interested parties together through a networking pipeline for mentorship opportunities, employment referrals, guidance for financial assistance, and any other referral needs that emerge over time.

Maintaining PMF as a Viable Organization

In order for PMF to continue to implement activities and develop programs aimed at retaining and recruiting African American physicians, PMF must make concerted efforts to maintain its viability as an organization. The following actions should be considered in this regard:

1) **Maintaining organizational clarity and focus.** In their quest to grow and develop themselves, new organizations often have a tendency to lose their focus. Given that PMF is a relatively new organization, it is critical that the overall goal is maintained and supported. Review of organizational focus can be done through annual strategic planning retreats, an event that allows the board and staff to review

past events as they relate to the overall goal of the organization, as well as provide insight (and/or foresight) into future activities as they pertain to the organization's aim in recruiting and retaining African American physicians in the local geographical area. The retreat also serves as a way for the organization to hold itself accountable for all organizational endeavors and activities in order to ensure that its mission is being met: to retain and recruit African American physicians; to eliminate health disparities and improve access to care for African American and other underserved communities in the Bay Area.

2) **PMF should continue to seek opportunities to maintain and build a financial base.** Currently, PMF's financial base is primarily supported by a single grant from Alta Bates/ Summit Medical Center (ABSMC). While the ABSMC grant has been instrumental in PMF's efforts to develop itself as an organization and has provided the initial funding needed to formulate program plans and conduct a preliminary needs assessment, this funding is not sufficient to support future programs and will eventually end. Therefore, PMF should devote substantial attention to increasing its financial base through continuous fundraising activities, grant writing and program development efforts. PMF may also consider partnering with other medical organizations, such as Sinkler Miller Medical Association, for fundraising, which would be a benefit for PMF as well as other organizations with similar interests.

3) **PMF should consider investing in medical related real estate property.** Given the economic challenges faced by physicians interested in conducting a solo or two-physician practice due to high cost of facilities (rent/leasing cost), PMF should consider investing in medical facility real estate properties. Such investments would allow the organization to work with physicians, and be part of the solution for addressing one of the major concerns of physicians - - the high costs of running a medical office. Purchasing medical related real estate properties also exhibits the organization's vested interest in its endeavors to address serious issues faced by physicians, such as financing, for those interested in having a private medical practice. For example, by owning such a property, PMF could help off-set the high cost of office leasing by allowing individuals or groups to rent or lease space at a reduced rate for an agreed upon time period. Although the other strategies that PMF may implement will be helpful in its undertaking of recruitment and retention, it is this major financial step that can help all parties involved in these efforts. For example, property ownership for PMF would not only assist physicians' financial needs, but would also be another financial asset for PMF to help strengthen its fiscal base.

Part V.

DISCUSSION

It has been argued that in order to develop effective strategies for addressing the supply of physicians available to various communities, policy makers must understand the how the supply of physicians are "poorly distributed across the state," particularly as it pertains to rural and urban communities (Grumbach, Coffman, Young, and Blick, 1998). In the case of PMF, the results from its Retention and Recruitment Study, will add to existing literature that strives to address and examine the issues associated with physician distribution within California, particularly, within African American communities and among African American physicians.

There are two key features associated with the PMF Retention and Recruitment study that lend themselves to the further understanding of the distribution of African American physicians within the Oakland-San Francisco Bay Area. Such an understanding helps in determining how to approach underserved communities, particularly those with high concentrations of African Americans. The first feature is that the PMF Registry is the first of its kind for the area. Secondly, the study looks at the distribution of African American physicians in great detail. Both factors provide the information needed in implementing strategies and/or policies that help to re-evaluate how physicians and services are distributed.

The PMF Registry

Though several directories exist, none are as comprehensive as that of the PMF Registry. For example, initial sources used to build the Registry contained several names that overlapped with one another, but this was not often the case. The American Medical Association, which keeps track of every person from entry to medical school on through their practice, provided a list with 335 names. Of these names only 124 names were duplicated in the Sinkler Miller Medical Association Directory. This was a similar pattern found with other sources, thus it became the goal of PMF to find as many names as possible. To date, the PMF Registry contains the names and information on 669 African American physicians, of which 592 (88%) are either legally practicing or in-training. Though the numbers of those in practice and/or training may seem small, they represent and are part of a comprehensive and accessible database. Having access to such a large number of African American physicians aids PMF in its efforts of retaining and recruiting physicians to the area.

The Registry also provides PMF with figures needed to start determining where there are true physician shortages, a feat that will prove challenging given the guidelines used by state and federal agencies. For example, currently the federal Primary Care Health Professionals Shortage Area guidelines suggest that a shortage area is one where there is less than one primary care physician per 3,500 people (U.S. Department of Health and Human Services, 1993). In the case of the Oakland-San Francisco Bay Area, only five neighborhoods in San Francisco qualify as such, and the neighborhoods designated do not have large numbers of African Americans (U.S. Department of Health and Human Services, 2005). It is known, however, that certain communities with sizeable African American populations in Oakland (Alameda County Health Status, 2003) and Richmond are faced with certain health disparities such as diabetes, hypertension and cancer, thus determining how to increase the availability African American physicians is crucial. With the existence of Registry, PMF has access to a large number of physicians and hopefully will be

able to implement tactics and programs that help to retain and recruit them to the areas that are faced with health disparities.

Detailed Physician Distribution

One of the many concerns of not only PMF but other medical provider agencies is that of the availability of primary care physicians. Through the Registry, PMF has been able to gather extensive information on local physicians, particularly on the number of primary care physicians. Such information can guide the direction in which PMF needs to go to make its retention and recruitment efforts successful. For example, review of the Registry found that almost half (49%) of its practicing physicians were primary care physicians. Similarly, almost half (46%) of the residents were practicing a primary care specialty. Both physician demographics are encouraging and make it even more important that PMF continue to develop efforts to recruit and retain its targeted physicians.

Though the distribution of primary care physicians is not equal across the targeted counties, access to such information that details where physicians are located, assists in determining the areas that require or need attention in terms of recruitment. For example, a common theme from the focus groups was the concern about the impact of managed care on African American physicians as well as patients. Review of types of practice found that about one-third (34%) of the practicing physicians belonged to a physician group or HMO. As the Registry grows and continues to be managed, PMF is able to keep track of trends and changes around managed care and African American physicians. Access to such information allows PMF to provide physician distribution information to the public and policy makers that may be useful in devising policies that help to even out the distribution of physicians across various communities.

Conclusion

It may be asked why is it so important in the 21st century to establish a registry or database of African American physicians, residents and medical students, particularly in the Oakland-San Francisco Bay Area, an area known for its liberalism. Furthermore, it could be argued the most important thing in healthcare is the quality of care and a system that supports the provision of such care. All notions may be true. There still remains the fact that healthcare disparities are very real, and for some communities, a common understanding. Focus group findings acknowledge that African American patients understand and recognize these issues and therefore seek out cultural connections when visiting with their physician and feel that it is critical to have African American physicians available to address these concerns. Thus, the challenge that remains for PMF is to retain those in practice and successfully recruit those in training who can address the issues of health disparities and provide culturally competent healthcare.

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Appendices

- Appendix A – PMF Registry Data Collection Tool
- Appendix B – Registry Codebook
- Appendix C – Focus Group Questions
- Appendix D – Additional Tables
- Appendix E – Medical Board of California Loan Repayment Application
- Appendix F – County Maps by Specialties
    - Alameda County: General Practice Specialties
    - Contra Costa County: General Practice Specialties
    - San Francisco County: General Practice Specialties
    - Alameda County: Additional Specialties
    - Contra Costa County: Additional Specialties
    - San Francisco County: Additional Specialties

Appendix A - PMF Registry Data Collection Tool

Circles Like This--> ●
Not Like This--> ⊗ ✓

Physicians Medical Foundation
Registry Form

Information from this form assists PMF in obtaining the most accurate and updated information about the physicians that the Registry is targeting. We ask that you take a few moments to complete this form. Upon completion, please return the form via fax to our office @ 510.874.7701.

Should you have any questions, please do not hesitate to call @ 510.874.7700.

BASIC INFORMATION

Please print name below:

Last Name First Name

Please print primary office address information below: If you are a RESIDENT, fill in primary site of residency.

Street

City State

Phone Fax

E-mail

LICENSE INFORMATION

Enter your California Physician and Surgeon License type and number:

License Type:
○ A ○ AFE ○ C
○ CFE ○ G ○ GFE

License Number:

I. ACTIVITIES IN MEDICINE

Current Place(s) of employment: (Fill in all that apply)

- ○ City/County Hospital
- ○ City/County Clinic
- ○ Group Practice
- ○ HMO
- ○ Kaiser Permanente
- ○ Medical School
- ○ Non-Governmental Hospital
- ○ Other Federal Agency
- ○ Self-Employed Practice
- ○ Two Physician Practice
- ○ Veteran Affairs Agency
- ○ Other:
- ○ Non-Patient Care

Indicate hours per week for each of the following activities. Fill in one circle on each line:

	None	1-9	10-19	20-29	30-39	40+
Patient Care	○	○	○	○	○	○
Research	○	○	○	○	○	○
Teaching	○	○	○	○	○	○
Administration	○	○	○	○	○	○
Consult to industry/ other agencies	○	○	○	○	○	○
Other	○	○	○	○	○	○

II. CURRENT STATUS

Current status: (Fill in the one that applies)

- ○ Practicing
- ○ Resident
- ○ Fellow
- ○ Med Student
- ○ Retired
- ○ Sabbatical

III. PRACTICE LOCATION

If you provide patient care, indicate the zip code of your primary practice location.

IV. MEDICAL PRACTICE A) Mark your primary (1°) practice area; B) Mark your secondary (2°) practice area (if applicable); and C) mark all specialties in which you are Board Certified (BC) by an American Board of Specialties' board or by the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine, or the American Board of Spine Surgery.

1°	2°	BC		1°	2°	BC		1°	2°	BC	
○	○	○	Aerospace Medicine	○	○	○	Hematology	○	○	○	Pediatrics
○	○	○	Allergy & Immunology	○	○	○	Infectious Disease	○	○	○	Physical Med & Rehab
○	○	○	Anesthesiology	○	○	○	Internal Medicine	○	○	○	Plastic Surgery
○	○	○	Cardiology	○	○	○	Medical Genetics	○	○	○	Psychiatry
○	○	○	Colon & Rectal Surgery	○	○	○	Neonatal Perinatal Med	○	○	○	Pub. Health & Genl. Prev. Med.
○	○		Complementary & Alternative Med	○	○	○	Nephrology	○	○	○	Pulmonology
○	○		Cosmetic Surgery	○	○	○	Neurological Surgery	○	○	○	Radiation Oncology
○	○	○	Critical Care	○	○	○	Neurology	○	○	○	Radiology
○	○	○	Dermatology	○	○	○	Nuclear Medicine	○	○	○	Rheumatology
○	○	○	Emergency Medicine	○	○	○	Obstetrics & Gynecology	○	○	○	Sleep Medicine
○	○	○	Endocrinology	○	○	○	Occupational Medicine	○	○	○	Spine Surgery
○	○	○	Facial, Plastic & Reconstructive Surg.	○	○	○	Oncology	○	○	○	Sports Medicine
○	○	○	Family Practice	○	○	○	Ophthalmology	○	○	○	Surgical Oncology
○	○	○	Gastroenterology	○	○	○	Orthopedic Surgery	○	○	○	Thoracic Surgery
○	○		General Practice	○	○	○	Otolaryngology	○	○	○	Urology
○	○	○	General Surgery	○	○	○	Pain Medicine	○	○	○	Vascular Surgery
○	○	○	Geriatric Medicine	○	○	○	Pathology	○	○	○	Other

V. POSTGRADUATE TRAINING Indicate (fill-in) the total years of training after medical school (approved by either the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada) you have completed.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9+

We would like to thank you again for taking a few moments to complete this form. Should you have any questions or concerns, please do not hesitate to call PMF at 510.874.8770.

For Office Use Only

2

Appendix B – PMF Registry Codebook

List of Variables in PMF Registry

Variable Name

MAILLAST = Mail last name

MAILFIRS = Mail first name

MAILNAME = First and last name

SUFFIX = Suffix to Name

KAISER = Kaiser Permanente?

Responses

- Yes
- No

PRIMARY = Primary Specialty

Responses

- Undetermined
- Allergy & Immunology
- Anesthesiology
- Colon & Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Practice
- Medical Genetics
- Internal Medicine
- Neurological Surgery
- Nuclear Medicine
- Ob/Gyn
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine & Rehab
- Plastic Surgery
- Preventive Medicine
- Psychiatry & Neurology
- Radiology
- General Surgery
- Thoracic Surgery
- Urology
- Rheumatology
- Addiction Medicine
- Gastroenterology
- Pain Management
- Cardiovascular Disease
- Infectious Disease
- Oncology
- Aerospace Medicine
- Complimentary & Alternative
- Cosmetic Surgery
- Critical Care
- Endocrinology Medicine
- Reconstructive Surgery
- General Practice
- Geriatric Medicine
- Hematology Medicine
- Genetics
- Neonatal/Perinatal
- Nephrology
- Occupational Medicine
- Pulmonology Medicine
- Radiation Oncology
- Sleep Medicine
- Spine Surgery
- Sports Medicine
- Surgical Oncology
- Vascular Surgery

RESISTAT = Person is a Medical Student or Resident?
Response

- Not a Resident or Med Student	- Kaiser Resident
- UCSF Resident	- CHO Resident
- Stanford Resident	- UCLA Med Student
- UC Davis Resident	- UC IRVINE Med Student
- ACMC Resident	- UCLA Resident
- UCSF Medical Student	- Undergrad
- Stanford Medical Student	- UC DAVIS Med Student
	- USC Med Student

TYPEPRA1 = Type of Practice
Response

- Resident	- Semi-Retired
- Direct Patient Care	- Temporarily Not in Practice
- Administration	- Not Active for Other Reasons
- Medical Teaching	- Unclassified
- Medical Research	- Medical Student
- Non-Patient Care	- Pre-Med
- Retired	

PHONENUM = Phone number

FAXPH = Fax Number

EMAIL = E-mail Address

OFCSITE = Office Site

OFCADD = Office Site Address

OFCCITY = Office Site City

OFCSTATE = Office Site State

OFCZIP = Office Site Zip

COUNTY = County Where Business is Located
Response

- Other (San Mateo, Santa Clara Counties or Other)	- Contra Costa
- Alameda	- San Francisco
	- Solano

ALTSITE = Alternate Site

ALTADDRE = Alternate Site Address

ALTCITY = Alternate Site City

ALTSTATE = Alternate Site State

ALTZIP = Alternate Site Zip

LICSTATU = Status of License

Response

- Renewed & Current	- Delinquent
- Surrendered	- Permanent Cont.Ed. Waiver
- Revoked	- License in Voluntary Service
- Retired	- No Record of License
- Cancelled	- Deceased
- Public Reprimand	- Suspended
- Cont. Ed. Required	- Renewal Pending
- Probation Completed	

STATE# = State Medical License Number

EMPLOY1 = Current Place of Employment, First Place

Response

- Self-Employed Solo Practice	- City/County/State Hospital
- Two Physician Practice	- City/County/State Clinic
- Other Patient Care	- City/County/State Non-Hospital
- Locum Tenens	- Veteran Affairs
- Group Practice	- Other Fed Agency
- HMO	- Non-Patient Care
- Medical School	- Unclassified
- Non-Governmental Hospital	

SOURCE1 = Source of Info#1
SOURCE2 = Source of Info#2
SOURCE3 = Source of Info#3
SOURCE4 = Source of Info#4
SOURCE5 = Source of Info#5

Response

- ACCMA	- UCSF Student/Resident
- AMA	- Highland Resident
- JHMA	- Clinic List
- NMA	- Stanford Resident/Fellow
- SFMA	- Stanford Med Student
- Sinkler Miller	- Kaiser
- SNMA	- CHO

GENDER = Gender

Response
- Male
- Female

MPASORT1 = Professional Level

Response

- Office Based Practice	- Research
- Resident	- Not Classified
- Medical Teaching	- Hospital Staff
- Administration	- Locum Tenens

MEDSCHNA = Medical School Name

MEDSCHOO = Medical School Year of Graduation

MEDSCHST = Medical School State

MEDSCHUS = Medical School US or Foreign?

RACEDESC = Race Descriptor

MDORDO = MD or DO?

CERTIFRB = Certification with American MedBoard

Response
- No
- Yes
- DK

CERTIFIC = Certificate Name/Type

BC1 = Board Certification #1

BC2 = Board Certification #2

BC3 = Board Certification #3

SUBSPEC1 = Sub Spec Board Name1

SB#1 = Sub Spec Board Lic #1

SUBSPEC2 = Sub Spec Board Name2

SB#2 = Sub Spec Board Lic #2

SUPSPEC3 = Sub Spec Boardname3

SB#3 = Sub Spec Board Lic #3

Appendix C – Focus Group Questions

PMF Physician Focus Group Questions

- Why did you choose to practice medicine in the Bay Area?
- In general, what has your medical practice experience been like in the Bay Area?
- What have been your main challenges/barriers to practice in this area? Are these challenges unique to the Bay Area? Why?
- In terms of serving the underserved populations in Alameda, Contra Costa, and San Francisco counties, what kinds (?) of physicians are in short supply? Why?
- Increasing the supply of / recruiting African American physicians to this area requires multiple strategies. Financial incentives is one strategy that has worked with federal programs to recruit physicians to underserved communities. What is your perception of financial incentives as a strategy to recruit physicians to this area?
- What are your impressions about medical education strategies (i.e. programs that encourage residency in target area)?
- What are your impressions of applicant-pool strategies (i.e. increasing the number of African Americans into medical school)?
- What are some other incentives that would encourage African American physicians to practice in underserved communities in Alameda, Contra Costa, and San Francisco counties?
- What other strategies do you feel will successfully recruit African American physicians to the Bay Area?

Appendix D – Additional Tables

Table A. Residents Without a Record of a Medical License

Residency	N
• ACMC	2
• CHO	3
• Kaiser	4
• Stanford	8
• UCLA	1
• UCSF	8
• Uncertain	5
TOTAL	**43**

Table B. Physicians' Specialties in Counties where Practice is Located

Count

	County where business is located						
	Other = San Mateo, Santa Clara Counties or Others	Alameda	Contra Costa	San Francisco	Solano	Central California Counties	Total
Undetermined	4	9	2	6			21
Anesthesiology	2	9	3	5		1	20
Dermatology		4	1	6			11
Emergency Med	1	6	5	1		1	14
Family Practice	2	23	12	7		1	45
Internal Medicine	1	47	14	13	1		76
Neurological Surgery		2		4			6
ObGyn	1	26	4	6		2	39
Ophthamology		7	1	2			10
Orthopaedic Surgery	1	9	3	3			16
Otolaryngology		3		1			4
Pathology		1		1			2
Pediatrics	3	31	6	8		1	49
Physical Med & Rehab		2		1			3
Plastic Surgery		1		4			5
Preventive Medicine	1	1					2
Psychiatry & Neurology		14	3	17			34
Radiology	1	3		3	1		8
Surgery	3	12	1	10			26
Thoracic Surgery		2	1	2			5
Urology		5	1	2			8
Rheumatology		1					1
Addiction Medicine				2			2
Gastro		3					3
Pain Management			1				1
Cardiovascular Disease		4		1			5
Infectious Disease		1		1			2
Oncology	1		2	3			6
Cosmestic Surgery		1					1
Nephrology			1				1
Pulmonology Med		1		1			2
Total	21	228	61	110	2	6	428

- A total of 30 specialties were practiced by those with renewed & current medical licenses.

- A small percentage (5% or 21 physicians) with renewed and current had primary specialties that could not be determined through other medical directories, online or telephone listings or with the California Medical Directory.

Table C. Physicians' Type of Practice by County

	County where business is located						
	Other = San Mateo, Santa Clara Counties or Other	Alameda	Contra Costa	San Francisco	Solano	Central California Counties	Total
Self-Employed Solo Practice	1	36	13	14		2	66
	5%	16%	21%	13%		33%	15%
Two Physician Practice		4	3	3			10
		2%	5%	3%			2%
Other Patient Care		1		3			4
		<1%		3%			1%
Locum Tenens		1					1
		<1%					<1%
Group Practice	3	53	11	22	1	1	91
	14%	23%	18%	20%	50%	17%	21%
HMO	4	29	14	7	1		55
	19%	13%	23%	6%	50%		13%
Medical School	1	2		7			10
	5%	1%		6%			2%
Non-Governmental Hospital	3	15	2	9			29
	14%	7%	3%	8%			7%
City/County/State Hospital		19	8	7			34
		8%	13%	6%			8%
City/County/State Clinic	1	12	1	4			18
	5%	5%	2%	4%			4%
City/County/State Non-Hospital	1	4	1	2			8
	5%	2%	2%	2%			2%
Veteran Affairs		2	2	2			6
		1%	3%	2%			1%
Non-Patient Care	1	4					5
	5%	2%					1%
Unclassified	6	46	6	30		3	91
	29%	20%	10%	27%		50%	21%
Total	21	228	61	110	2	6	428

Appendix E – Medical Board of California Loan Repayment Application

California Physicians Corps Loan Repayment Application

Instruction Sheet

For The California Physician Corps

Loan Repayment Program Application

The California Physician Corps Loan Repayment Program (Program@) was created through a new law sponsored by the Medical Board of California (Board@). The Board recognizes the necessity of improving conditions which lead to healthcare disparities in the state, including those disparities arising from cultural and linguistic barriers. At the same time, the Board acknowledges the difficulty of many culturally or linguistically competent physicians to practice in underserved areas because of the heavy debt load that they carry from acquiring a medical education. This program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their educational loans in exchange for their service in a designated underserved area for a minimum of three years.

Qualifications and Eligibility Criteria: Program participants must hold a full and unrestricted license to practice medicine in California and be willing to commit to a minimum of three years of service under this program. The most qualified applicants will be selected in the areas of California with the greatest need: health care settings in medically underserved areas with at least 50 percent of the patients from a medically underserved population. Priority consideration will be given to the applicants best suited to meet the cultural and linguistic needs and demands of patients, based on the applicant meeting one or more of the following criteria:

speak a Medi-Cal threshold language

come from an economically disadvantaged background

have received significant training in cultural and linguistically appropriate service delivery

have three years of experience working in medically underserved areas or with medically underserved populations

have recently obtained their license to practice medicine in California

Preference will be given to those applicants who have completed a three-year postgraduate residency in the areas of family practice, internal medicine, pediatrics, or

obstetrics/gynecology; however, up to 20 percent of the available positions may be filled by applicants from other areas. Other criteria will be used in selecting those persons best suited for this program

Licensure to Practice Medicine in California: If you are not licensed to practice medicine in California when you apply to the loan repayment program, you must ensure that your Physician's and Surgeon's Application is submitted to the Medical Board promptly. In order to be eligible for participation in the loan repayment program, you must be licensed in California before the final filing date for each application period. If you are not licensed by the final filing date, the application shall not be considered and shall be returned to the applicant.

Brief Definitions: These definitions are provided as a guideline for interested applicants. However, since this is a new program, the Board recommends that you check its Web site to get the most current regulatory changes to these definitions and other terms as they occur. Full legal definitions also will be included on the Web site.

Appendix E Con't.

Full Time - providing medical services for a minimum of 40 hours per week, for a minimum of 45 weeks per year. The 40 hours per week may be compressed into no less than four days per week, with no more than 12 hours of work in any 24-hour period. This does not include hours spent on call. At least 32 hours per week must be spent providing clinical services at the approved practice site(s) during normal office hours, except that, for physicians who are continuously engaged in the practice of obstetrics, at least 21 hours must be spent providing clinical services in addition to deliveries and other inpatient coverage. Absence from the practice cannot exceed 7 weeks in a calendar year except as otherwise required in order to comply with the Family Medical Leave Act and/or the California Family Rights Act. [This language has been proposed for regulatory approval.]

Medi-Cal Threshold Language - Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. A county-specific matrix is on the Web site.

Medically Underserved Area - as defined in Business and Professions Code Section 2154.2 (d), in part - an area as defined in the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist under the California Health and Safety Code

Medically Underserved Population - as defined in Business and Professions Code Section 2154.2 (e) - the Medi-Cal, Healthy Families, and uninsured populations.

Practice Setting - as defined in California Business and Professions Code Section 2154.2 (f) means, in part, either:

(1) A community clinic, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to the California Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(2) A medical practice located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

Recently Licensed - having been licensed to practice medicine for the first time in the United States or Canada within the past five (5) years.

Speak - the ability to communicate with fluency in the threshold language so that the doctor can describe to the patient his/her condition and provide instructions for medical care/treatment and so that the doctor can understand medical questions asked in that language.

CPCLRPA Instructions-WP 1/2003

Medical Board of California Page 2

California Physicians Corps Loan Repayment Application Instruction Sheet

Match between Applicants and Clinics: When submitting an application, the applicant may already be working at, or must have entered into a written agreement to provide services under this program with, an appropriate practice setting. If an applicant is proposing a work arrangement with multiple practice settings, the applicant shall list those clinics on a separate page and identify the percentage of hours to be provided at each site. If an applicant is interested in participating in this program but has not been able to match@ with a specific practice site, please check the Program's Web site. The Board will be listing those practice settings which are interested in recruiting physicians as well as unmatched@ applicants who are interested in participating in this program.

Appendix E Con't.

Loan Repayments:

1) The Medical Board of California, under the California Physician Corps Loan Repayment Program, is authorized to repay outstanding government and commercial educational loans only, for expenses incurred during undergraduate and graduate education (ie, principal, interest, and related expenses for tuition, educational expenses, and reasonable living costs). Award recipients are responsible for making continued loan payments during the course of their participation in this program, since the program only makes payments at the end of each service year.

2) A maximum of $105,000 may be made available to program participants as an educational loan repayment. After completing the first year of service, the participant may receive up to $25,000; after the second year, up to $35,000; and, after the third year, up to $45,000.

3) In no event shall the cumulative amount of the educational loan repayments exceed the amount of the participant's outstanding educational loan balances as of the date the written contract is signed between the Medical Board of California and the award recipient.

4) If the outstanding educational loan balances are less than $105,000, then 24 percent of the award will be granted at the end of the first year of service, 33 percent at the end of the second year of service, and 43 percent at the end of the third year of service.

5) The funds paid under this program are considered personal income, subject to taxation by the United States Internal Revenue Service and the California Franchise Tax Board. Please consult your tax advisor about the financial implications of this award.

6) Submittal of an application and a written agreement with a acceptable practice setting does NOT ensure that applicants will receive a loan repayment. The Board anticipates that many physicians will apply, but only a limited number of positions can be funded.

7) Applicants must submit a current loan statement for each educational loan for which they are seeking repayment. Each statement must clearly indicate: 1) the loan company's name, 2) the loan company's mailing address, 3) your name, 4) the loan account number, 5) the outstanding balance, and 6) the issue date of the loan statement.

Clinical Salaries: Clinics must pay prevailing wages to program participants. Clinics must agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

Application Deadlines: The deadline for the 2003 filing period is Friday, April 11, 2003. All applications and related documents must be received by the Medical Board of California by close of business on that date. An application that is not complete by, or is received after, close of business on the final filing date shall not be considered and shall be returned to the applicant.

Attachments: Please only include those attachments which are specifically requested on the application.

Written Contracts: Award recipients will be required to sign a written contract with Medical Board of California outlining the provisions which must be met to fulfill theobligations under this program. Breach of Contract provisions and penalties, as well as specifications for Leaves of Absence, still are being developed; these proposes regulations will be kept current on our Web site. If an accusation is filed against the award recipient by the Medical Board of California during the period of the contract, then the contract shall be null and void and the award recipient will held in breach.

Judgments and Liens Against the Applicant: In signing the application, the applicant is stating that there are no outstanding judgments or liens arising from State or Federal debt against the applicant.

Appendix E Con't.

Funding: The Board will make available $3 million to fund the program and seek matching funds from private sources or foundations. As the Board is able to secure additional funding for the program, additional filing dates will be posted. A new application will be required for each filing date. Applicants should continuously check the Board's Web site for future filing periods.

Questions: If you have further questions or comments about the California ***Physician Corps Loan Repayment Program***, you may contact the Medical Board of California at **(916) 263-2389**.

For your convenience, you may also send your questions or comments to:

MDLoan@medbd.ca.gov

Web Site Updates: Please check **www.medbd.ca.gov/mdloan.htm** for updates about the Program.

Mailing Address: Please mail your completed application and supporting documentation to:

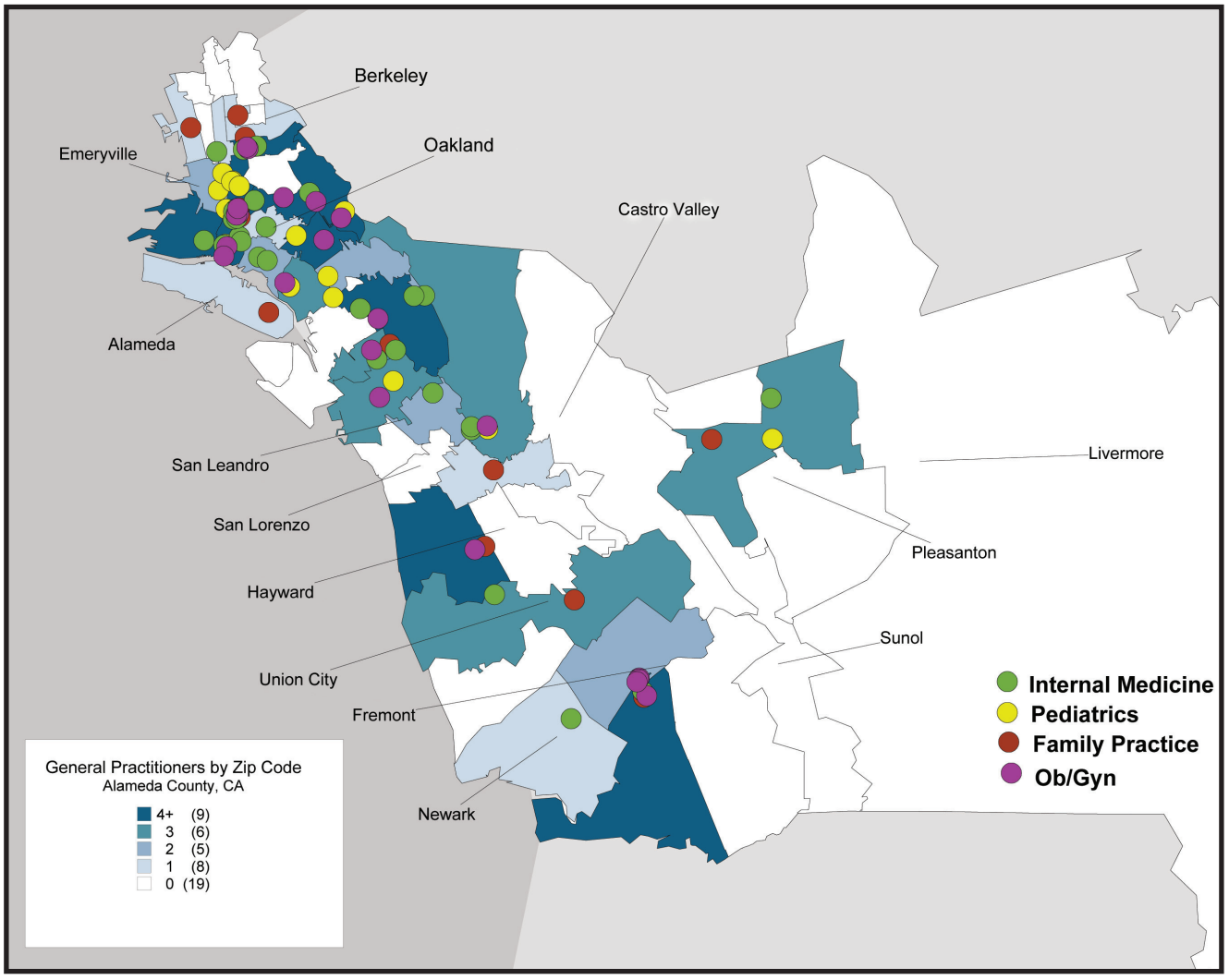
Medical Board of California
California Physician Corps Loan Repayment Program
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

Appendix F – County Maps by Specialties

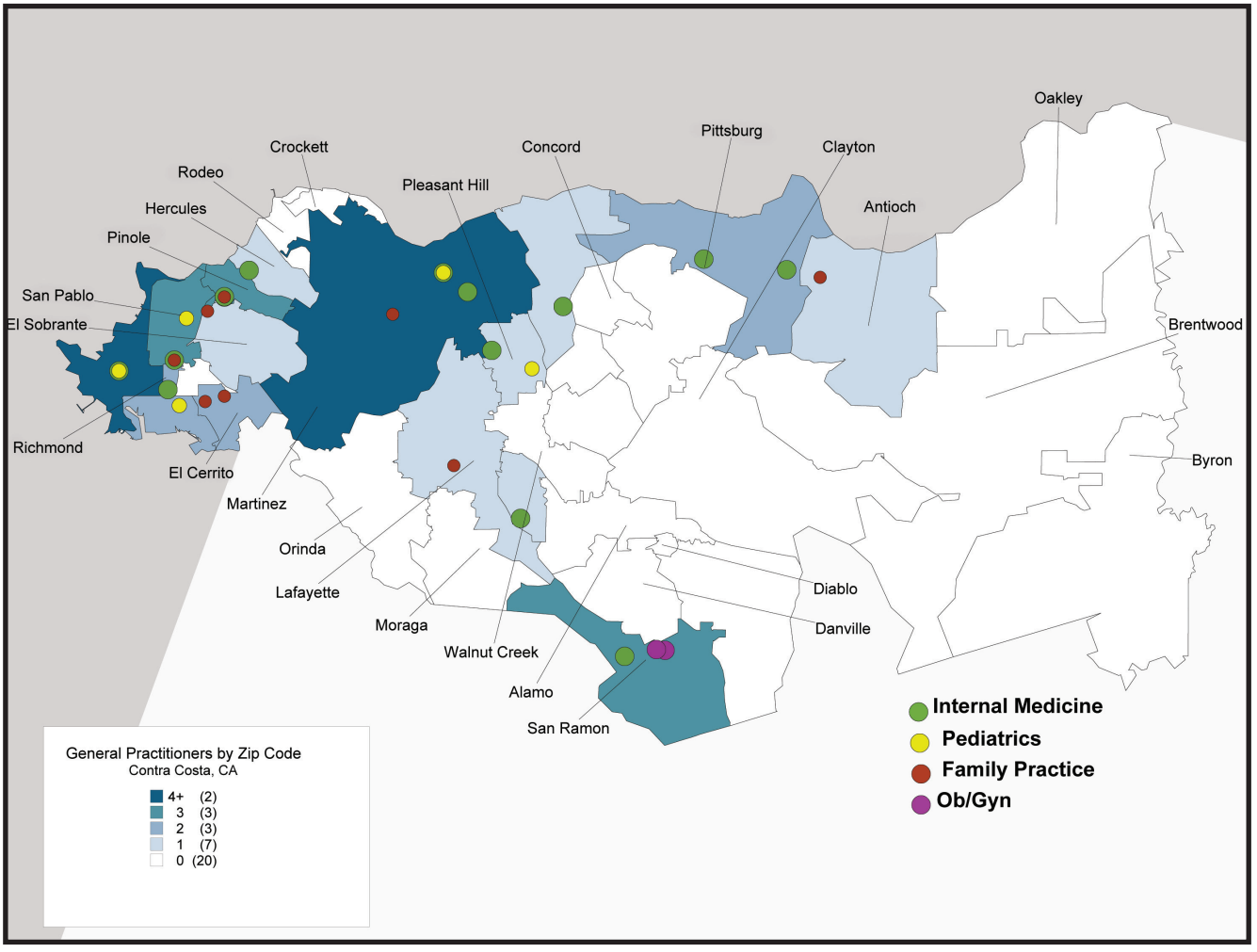
ALAMEDA COUNTY

GENERAL PRACTICE SPECIALTIES

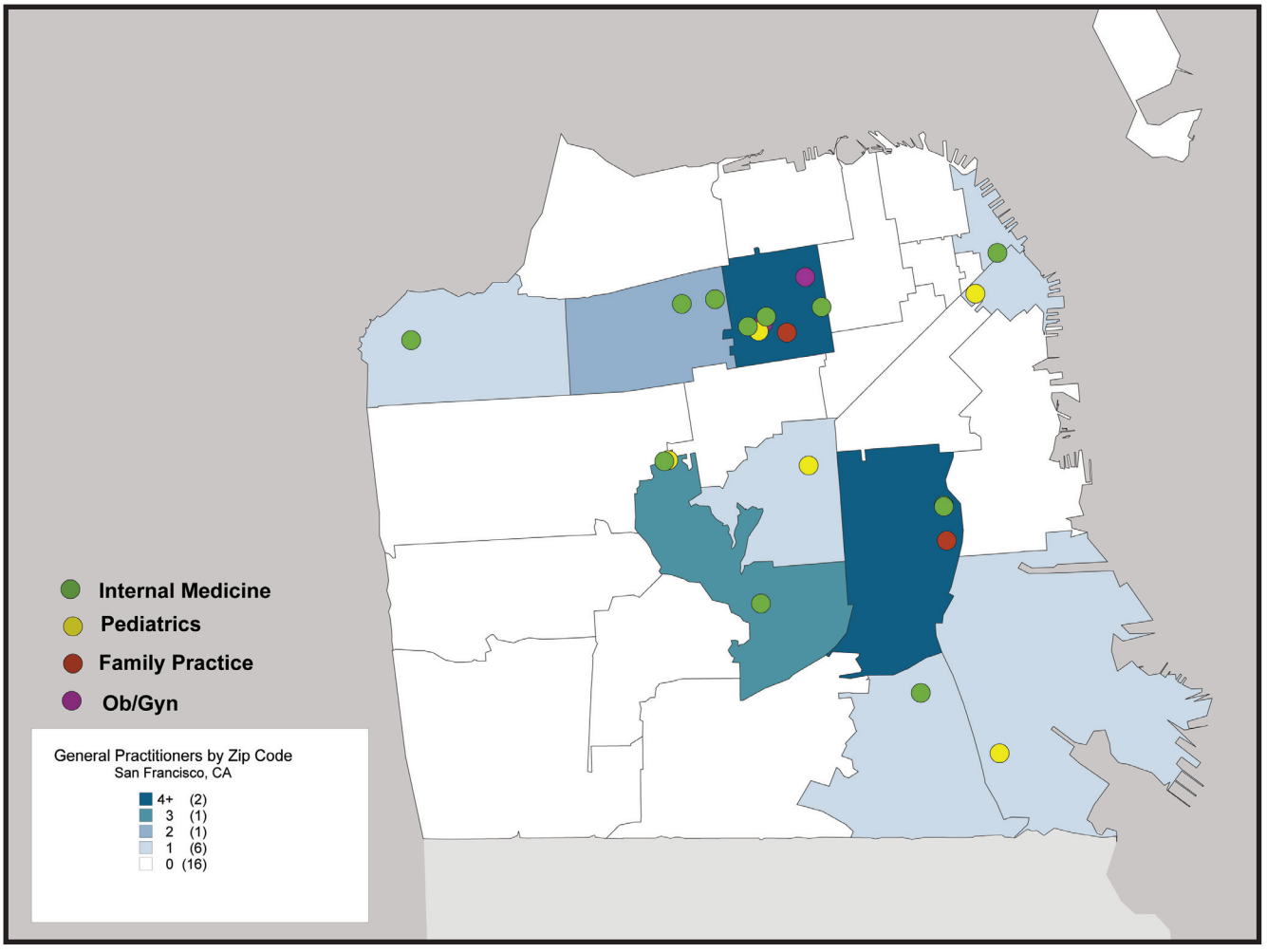
(Family Practice, Internal Medicine, Ob/Gyn, and Pediatrics)



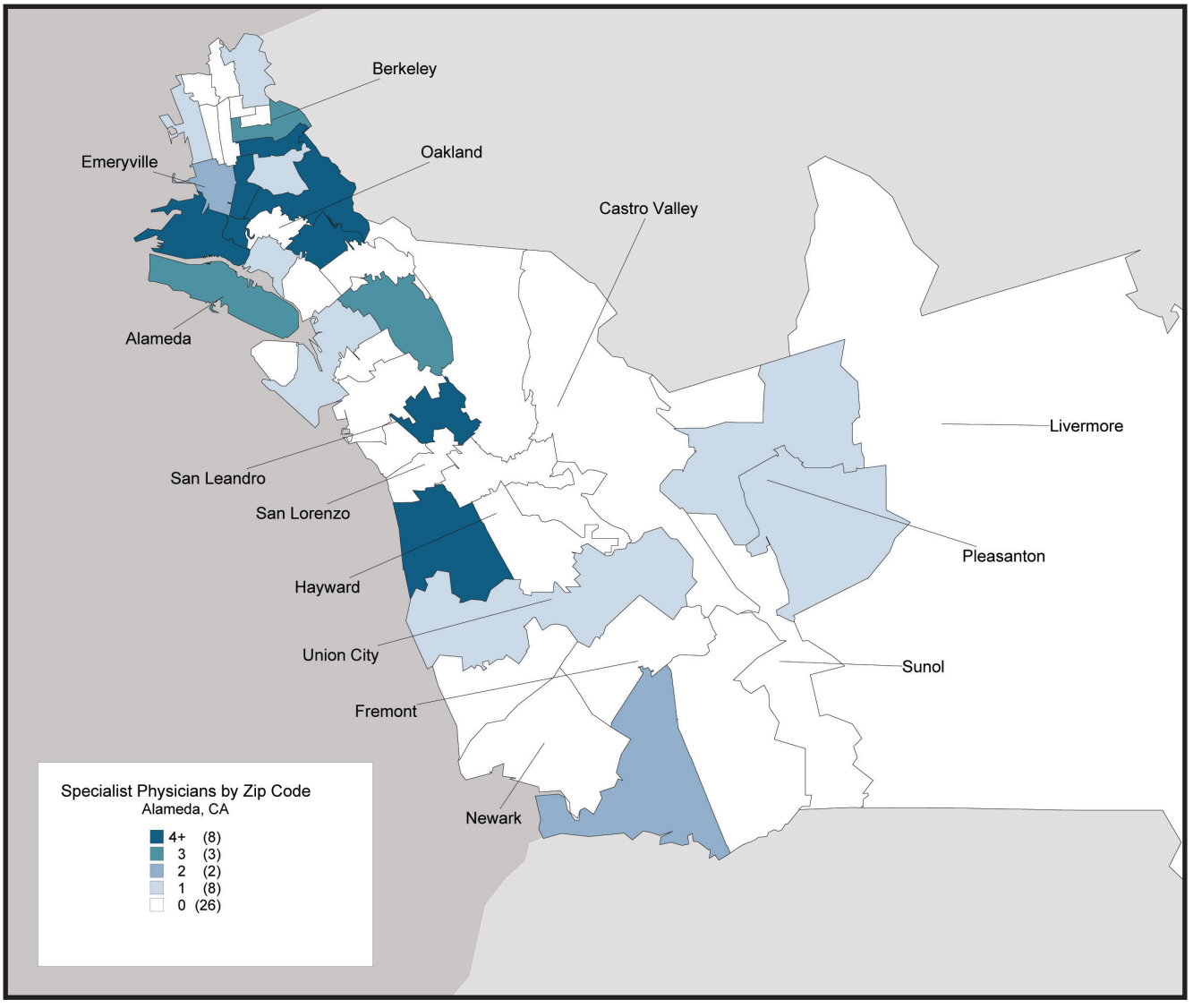
CONTRA COSTA COUNTY
GENERAL PRACTICE SPECIALTIES
(Family Practice, Internal Medicine, Ob/Gyn, and Pediatrics)



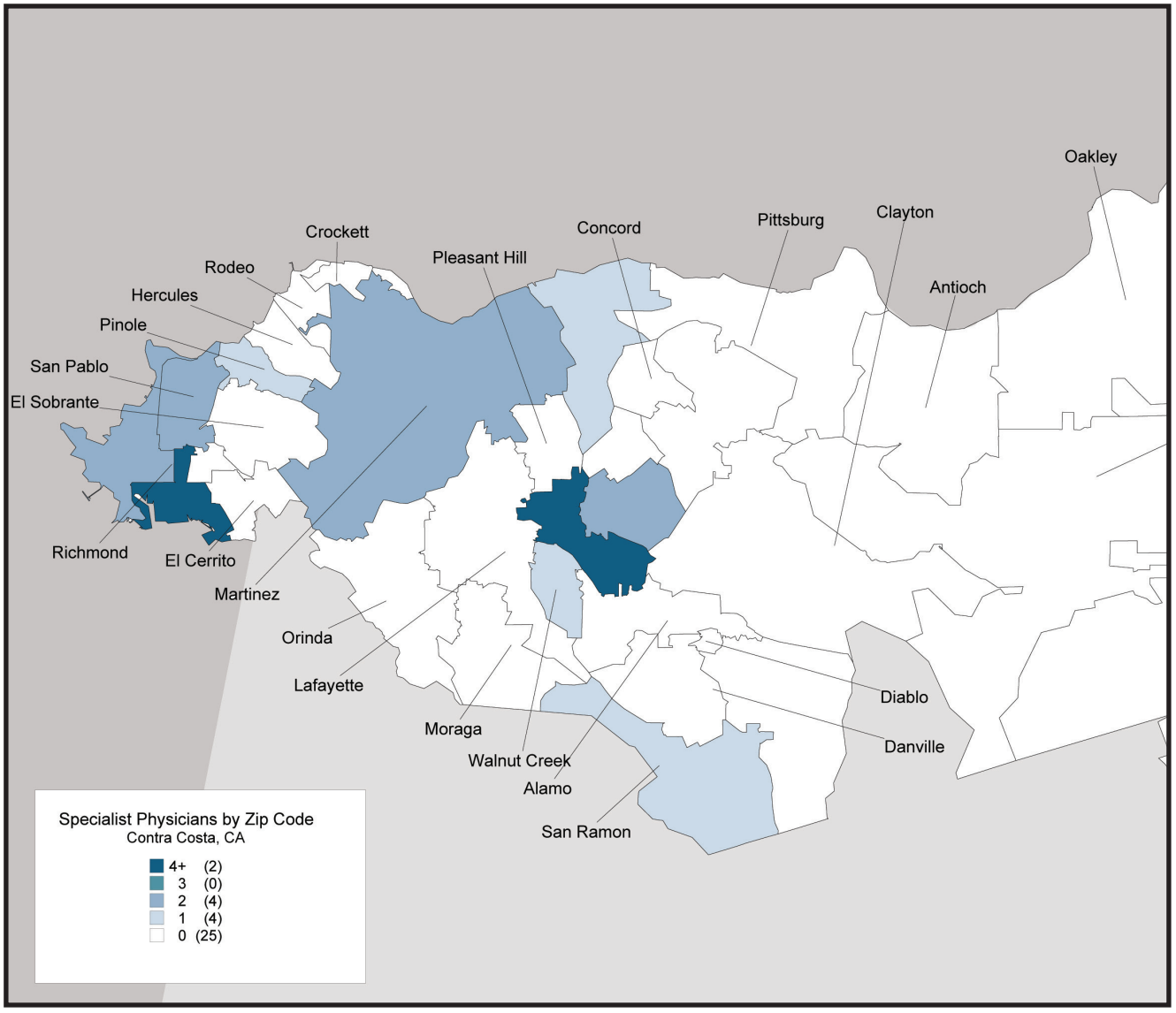
SAN FRANCISCO COUNTY
GENERAL PRACTICE SPECIALTIES
(Family Practice, Internal Medicine, Ob/Gyn, and Pediatrics)



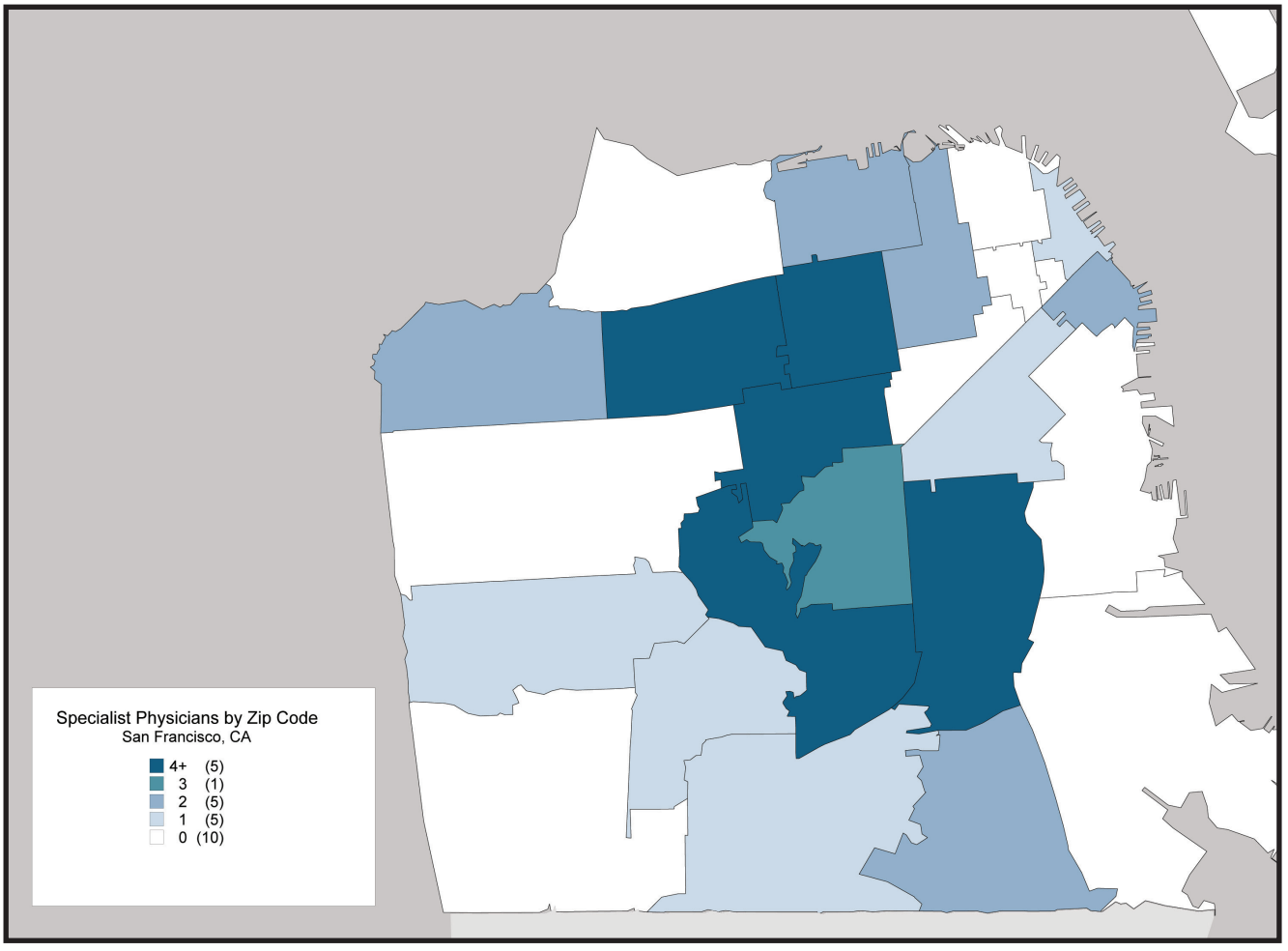
ALAMEDA COUNTY
ADDITIONAL SPECIALTIES
(Non-General Practice)



CONTRA COSTA COUNTY
ADDITIONAL SPECIALTIES
(Non-General Practice)



SAN FRANCISCO COUNTY
ADDITIONAL SPECIALTIES
(Non-General Practice)



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