

**Oregon Health Fund Board
Delivery System Committee Charter
Approved by OHFB on :**

I. Objective

The Delivery System Committee (“Committee”) is chartered to provide the Board with policy recommendations to create high-performing health systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

The Committee’s recommendation will serve as a cornerstone to the success of the Board’s final report. The work of the Committee is framed by several principles and goals outlined in SB 329:

- *Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcomes.*
- *Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability....*
- *Use proven models of health care benefits, service delivery and payments that control costs and overutilization....*
- *Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.*
- *Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year....*

The Board seeks, through the work of the Committee, more effective and efficient models of health care delivery that will address the health needs of all Oregonians through accountable health plans and other entities.

Bold and creative thinking is encouraged!

II. Scope

A. Assumptions:

In addition to the Board’s “*Design Principles & Assumptions*” (attached), the Committee’s work should be framed by the following assumptions:

1. While new revenue will be needed in the intermediate term to provide coverage to the currently uninsured, improving the performance of Oregon’s delivery systems should provide opportunity to recapture or redeploy resources with consequent reduction in the annual rates of increase in health care costs.

2. The Committee's recommendations on system changes and cost containing strategies should apply to Oregon's delivery systems broadly, not solely to programs for the uninsured.

3. Proposed strategies for containing the rate of health care cost increases should include estimates of "savings" over a defined time period. Such projections will be used by the Finance Committee in the development of overall revenue requirements.

4. The following concepts are of priority interest to the Board:

- **Primary Care**

Revitalizing primary care models to improve the capacity for and outcomes from preventive and chronic care services.

- **Managing Chronic Disease**

Strategies for comprehensive, coordinated and sustained clinical management of the chronic diseases that significantly impact overall health care expenditures.

- **New Reimbursement Models**

Strategies that move from fee-for-encounter (service) to financial incentives/rewards for providers who produce clinical outcomes that meet or exceed widely accepted standards of care.

- **Health Information Technology**

Public policies and public-private collaborations that will increase the rate of diffusion and use health information technologies (e.g. electronic health records, registries, etc.) and ensure the interoperability of such technologies.

- **Information Transparency**

Recommendations for a model Oregon Quality Institute that collects, measures and reports information on the performance of health care delivery systems including, but not limited to clinical quality and efficiency indicators. (See Oregon Quality Institute Work Group, below)

- **New Clinical Technologies**

Recommendations to assure that the "added value" of new clinical technologies is broadly understood and that avoid inappropriate diffusion and utilization.

- **Public Health & Prevention**

Strategies to develop, implement, sustain, evaluate and finance public health and public-private programs that target critical population health issues such as the obesity in Oregon's population.

- **End-of-Life Care**

Recommendations to improve end-of-life care that promote information about care options and advance directives, improve provider awareness of patient preferences and assure services for dignified care.

Note: The preceding list is not intended to limit the Committee's scope of investigation or recommendations.

B. Criteria:

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Does the recommendation improve the "value equation"? [Cost / Quality]
2. Does the recommendation contain the rate of growth of health care costs? Can the impact be measured objectively over time?
3. What is the anticipated timeframe for implementation?
 - Short term? (1 to 2 years)
 - Intermediate term? (3 to 5 years)
 - Long term? (5+ years)
4. Does the recommendation require public policy action (statutory or regulatory)? Are the "politics" for such action: Favorable? Mixed? Unfavorable? Unknown?
5. Is voluntary collaboration among purchasers, providers, payers or consumers required to implement the recommendation? What is the "readiness" of key stakeholder groups to support such an effort?

C. Deliverables:

The Board anticipates receiving 5 to 10 recommendations from the Committee that address, in a strategic manner, the development of high-performing, value-producing health care systems. The recommendations may be prioritized.

Each recommendation should include, at minimum:

- A complete description of the recommended strategy and its intended objective(s).
- The method(s) for measuring the impact of the strategy over time.
- Estimates of "savings" achieved over a defined period of time through containing the rate of cost increases.
- The estimated timeframe for implementation with key milestones and risks.
- The impact of the strategy on key stakeholders.
- Reference citations to clinical or health services research relied upon in developing the recommendation.

III. Timing

The Committee will deliver its recommendations to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

| Name | Affiliation | City |
|-----------------------------|---|-------------|
| Dick Stenson, Chair | Tuality Healthcare | Hillsboro |
| Maribeth Healey, Vice-Chair | Advocate | Clackamas |
| Doug Walta, MD, Vice-Chair | Physician | Portland |
| Vanetta Abdellatif | Multnomah Co. Health Department , Health Policy Commission (HPC) | Portland |
| Mitch Anderson | Benton County Mental Health | Corvallis |
| Tina Castanares, MD | Physician, Safety Net Clinic | Hood River |
| David Ford | CareOregon | Portland |
| Vickie Gates | Consultant, HPC | Lake Oswego |
| William Humbert | Retired Firefighter | Gresham |
| Dale Johnson | Blount International, Inc. | Portland |
| Carolyn Kohn | Community Advocate | Grants Pass |
| Diane Lovell | AFSCME, PEBB Chair | Canby |
| Bart McMullan, MD | Regence BlueCross BlueShield of OR | Portland |
| Stefan Ostrach | Teamsters, Local 206 | Eugene |
| Ken Provencher | PacificSource Health Plans | Eugene |
| Lillian Shirley, RN | Multnomah Co. Health Department | Portland |
| Mike Shirtcliff, DMD | Advantage Dental Plan, Inc. | Redmond |
| Charlie Tragesser | Polar Systems, Inc. | Lake Oswego |
| Rick Wopat, MD | Samaritan Health Services, HPC | Corvallis |

V. Staff Resources

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Oregon Quality Institute Work Group

Scope

In order to achieve a high-performing health care delivery system and contain cost increases, the State must work with providers, purchasers, payers and individuals to improve quality and transparency. The Oregon Quality Institute (“Institute”) work group will make recommendations on the State’s role in building on existing efforts to develop a public-private entity to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group’s recommendations will address:

- How should an Institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should an Institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can an Institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should an Institute address issues of legal discovery and liability?
- What role can an Institute play in engaging Oregonians to use available data when making health care decisions?
- How can the State encourage more effective and coordinated value-based purchasing? How can the State strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and those served by the Oregon Health Plan?

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

Work Group Membership

The Institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group.

**Oregon Health Fund Board
Eligibility & Enrollment Committee
Approved by OHFB on :**

I. Objective

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board. The work will be guided by the Board's "Design Principles & Assumptions".

II. Scope

The Eligibility and Enrollment Committee will focus its study of strategies to Eligibility requirements, including:

- 1) Affordability: public subsidies of premiums and other costs associated with the program that ensure program affordability at all incomes for individuals and sustainability for the state;
- 2) Enrollment Procedures: streamlined procedures, including: a standardized application process, application assistance, requirements to demonstrate Oregon residency, retroactive eligibility, waiting periods, preexisting condition limitations, other administrative requirements for enrollment;
- 3) Disenrollment: standards for disenrollment and changing enrollment in Accountable Health Plan;
- 4) Outreach: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and program's eligibility requirements and enrollment procedures; and,
- 5) ESI: process for allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

III. Timing

The Committee will provide its recommendation(s) to the Benefits Committee on public subsidies and affordability no later than January 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

| Name | Affiliation | City |
|-------------------------|---------------------------------------|-------------|
| Ellen Lowe, Chair | Advocate and Public Policy Consultant | Portland |
| Jim Russell, Vice-Chair | MidValley Behavioral Care | Salem |
| Robert Bach | Medicaid Advisory Committee (MAC) | Portland |
| Jane Baumgarten | Retired | Coos Bay |
| Dean Kortge | Pacific Benefits Consultants | Eugene |
| Felisa Hagins | SEIU Local 49 | Portland |
| Noelle Lyda | Ed Clark Insurance Inc. | Salem |

| | | |
|-----------------|-------------------------------|---------------|
| CJ McLeod | The ODS Companies | Portland |
| John Mullin | Oregon Law Center | Portland |
| Bill Murray | Doctors of Oregon Coast South | Coos Bay |
| Ellen Pinney | Oregon Health Action Campaign | Corbett/Salem |
| Susan Rasmussen | Kaiser Permanente | Portland |
| Carole Romm | Central City Concern, MAC | Portland |
| Ann Turner, MD | Virginia Garcia Health Center | Cornelius |

V. Staff Resources

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**Oregon Health Fund Board
Federal Laws Committee Charter
Approved by OHFB on :**

I. Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

II. Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Healthy Oregon Act including, but not limited to, the following:

- 1) Medicaid requirements such as eligibility categories and household income limits and Medicaid waivers;
- 2) Medicare policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate."
 - o The Committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access.
 - o The Committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.
- 3) Employment Retirement Income Security Act (ERISA) requirements and the extent to which it is clear what state action is permissible without further decisions by the federal courts;
- 4) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
- 5) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient" and EMTALA waivers; and
- 6) The Health Insurance Portability and Accountability Act (HIPAA) and any other area of federal policy that inhibit Oregon's ability to move forward with health care reform efforts.

III. Timing

In December 2007 and January 2008, the Committee will solicit written comments from the public and key stakeholders on the impact of federal policy on Oregon's reform efforts and recommendations to remove barriers to these efforts. From January - April

2008, the Committee will hold a series of meetings to include panels of stakeholders to present on and discuss selected areas of federal policy. The results of these meetings will inform the Committee's findings and recommendations.

The draft report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation.

Although SB 329 requires this report no later than July 31, 2008, the Board will request the Oregon Legislature's approval to change the due date to October 1, 2008. This change will allow the report of this Committee to be presented in a series of public hearings during the summer of 2008 along with the Board's draft comprehensive plan. Public comments gathered at these meetings will be incorporated into the final report. Whether or not the deadline change is approved, the Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

IV. Committee Membership

| Name | Affiliation | City |
|----------------------------|-------------------------------------|-------------|
| Frank Baumeister, Chair | Physician | Portland |
| Ellen Gradison, Vice Chair | Oregon Law Center | Corvallis |
| Mike Bonetto | ZoomCare | Bend |
| Chris Bouneff | DePaul Treatment Centers | Portland |
| Michael Huntington, MD | Retired Physician, Archimedes | Corvallis |
| Julia James | Consultant | Bend |
| Mallen Kear, RN | Retired Nurse, Archimedes | Portland |
| Sharon Morris | Health Care Administrator (retired) | Grants Pass |
| Larry Mullins, DHA | Samaritan Health Services | Corvallis |
| Nicola Pinson | OR Primary Care Association | Portland |
| Tom Reardon, MD | Retired Physician | Portland |

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**Oregon Health Fund Board
Health Equities Committee
Approved by OHFB on :**

I. Objective

The Health Equities Committee (“Committee”) is chartered to develop multicultural strategies for program eligibility and enrollment procedures and policy recommendations to reduce health disparities through delivery system reform and benefit design in the Oregon Health Fund program. Guided by the Board’s *“Design Principles & Assumptions”*, the work of the Committee will be submitted directly to the Oregon Health Fund Board (OHFB) as well as integrated into the work of other OHFB committees.

II. Scope

The Committee will focus its study on strategies to reduce health disparities in Oregon, including but not limited to:

1. Providing the Eligibility & Enrollment Committee with recommendations concerning:
 - Best practices for outreach in communities of color, homeless adults and youth, and with individuals who live in geographic isolation.
 - Strategies to reduce disparities in insurance status by decreasing barriers to enrollment and streamlining enrollment policies & practices.
2. Providing the Delivery System Committee with recommendations concerning reducing health disparities in Oregon. Recommendations may include:
 - Elements of the Medical Home model that reduce health disparities and provide culturally competent care.
 - Financial incentives for providers to reduce targeted health disparities and improve quality care.
 - A plan to increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
 - Provider workforce issues such as recruitment of minority and rural providers, retention, and cultural-competence training.
 - Methods to empower and incentivize individuals to make healthy lifestyle choices.
 - Reimbursement options for health promotion activities that occur outside of the traditional healthcare delivery system.
3. Providing the Benefits Committee with recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations including:

- Benefits related to women’s health and benefit designs that target women of childbearing age.
- An emphasis on reducing health disparities in developing a benefit package of essential health services.
- Ensuring an affordable benefit package that promotes the health of individuals who have physical or mental health disabilities.

III. Timing

The Committee will provide its recommendation(s) to the Eligibility and Enrollment Committee on no later than January 15, 2008, to the Delivery Committee no later than February 15, 2008, to the Benefits Committee no later than March 15, 2008 and all other recommendation(s) to the Board no later than April 30, 2008.

IV. Committee Membership

| Name | Affiliation | City |
|--|---|-------------|
| Ella Booth, Ph.D., Chair | Oregon Health & Science University (OHSU) | Portland |
| Joe Finkbonner Vice Chair | Northwest Portland Indian Health Board | Portland |
| Tricia Tillman, MPH, Vice Chair | Multnomah County Health Department | Portland |
| Michelle Berlin, MD, MPH | Center of Excellence in Women’s Health, OHSU | Portland |
| Ed Blackburn | Central City Concern | Portland |
| Bruce Bliatout, Ph.D., | Multnomah County Health Department | Portland |
| John Duke, MBA | Outside-In Homeless Youth Clinic | Portland |
| Honora Englander, MD | OHSU Division of Hospital Medicine | Portland |
| Scott Ekblad | Office of Rural Health, OHSU | Portland |
| Yves LeFranc, MD | Legacy Health Systems | Portland |
| Holden Leung, MSW | Asian Health and Service Center | Portland |
| Jackie Mercer | NARA | Portland |
| Maria Michalczyk, RN, MA, | Healthcare Interpreter Training program, Portland Community College | Portland |
| Melinda Muller, MD | Legacy Health Systems | Portland |
| Laurie Powers, Ph.D. | Portland State University, Reg. Research Institute | Portland |
| Noelle Wiggins | Multnomah County Health Department | Portland |

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A Comprehensive Plan for Reform: Design Principles & Assumptions

Design Principles

I. Optimize health: Wellness, prevention, early intervention & chronic disease management are strategic priorities.

II. Effective markets provide useful information to producers & purchasers.

III. The responsibility & accountability for the financing and delivery of health care is shared by all Oregonians.

IV. Oregon's health care financing & delivery system must be designed & operated for long-term sustainability.

V. Financial barriers to affordable coverage are removed.

VI. Reforms will build on the foundational elements of the current system.

Design Assumptions

A. Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care. **[BETTER OUTCOMES & ↓ COST GROWTH]**

B. Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. **[INFORMATION → ↑ QUALITY & EFFICIENCY]**

C. All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

D. Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system. **[PLAY OR PAY]**

E. Public financing will be broad-based, equitable & sustainable. **[FISCALLY FAIR & RESPONSIBLE]**

F. The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable. **[A NEW MARKET = NEW RULES]**

G. Public subsidies will be available to assist defined populations to obtain affordable coverage. **[ASSIST THOSE IN NEED]**

H. - Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.
- A FHIAP-like program will serve Oregonians within defined income levels through premium subsidies.
- The Oregon Health Plan (Plus & Standard) will serve Oregonians below defined income levels.

I. New revenue (tax) options will be required

OREGON HEALTH FUND BOARD

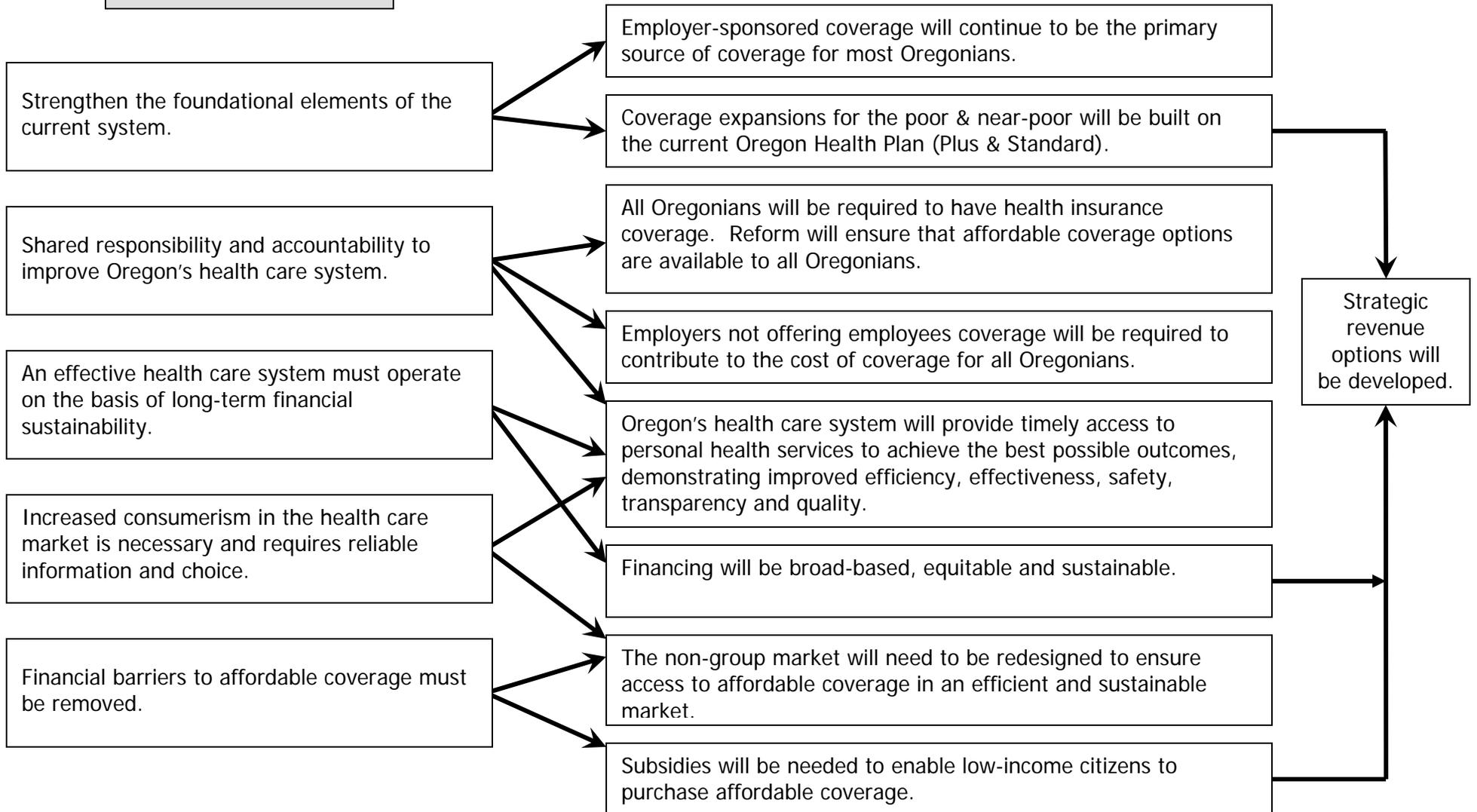
A Comprehensive Plan for Reform: Design Principles and Assumptions

Approved by OHFB _____

DRAFT OF 10/16/07

DESIGN PRINCIPLES

DESIGN ASSUMPTIONS



American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Physicians (ACP)

American Osteopathic Association (AOA)

February 2007

Introduction

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately

arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
1. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
 2. Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

1. It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
2. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
3. It should support adoption and use of health information technology for quality improvement;

4. It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
5. It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
6. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
7. It should recognize case mix differences in the patient population being treated within the practice.
8. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
9. It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving

patient care called the “medical home” (AAFP, 2004) or “advanced medical home” (ACP, 2006).

For More Information:

American Academy of Family Physicians

<http://www.futurefamilymed.org>

American Academy of Pediatrics:

http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians:

<http://www.acponline.org/advocacy/?hp>

American Osteopathic Association

<http://www.osteopathic.org>



CLOSING THE DIVIDE: HOW MEDICAL HOMES PROMOTE EQUITY IN HEALTH CARE

RESULTS FROM THE COMMONWEALTH FUND
2006 HEALTH CARE QUALITY SURVEY

Anne C. Beal, Michelle M. Doty, Susan E. Hernandez,
Katherine K. Shea, and Karen Davis

June 2007

ABSTRACT: The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.

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CONTENTS

| | |
|--|-----|
| List of Figures and Tables..... | iv |
| About the Authors..... | vii |
| Executive Summary..... | ix |
| Introduction: The Importance of Having Insurance Coverage and a Medical Home | 1 |
| Insurance Coverage Among African American and Hispanic Adults | 2 |
| Access to a Medical Home..... | 6 |
| Timely Receipt of Needed Care and Preventive Services..... | 9 |
| Management of Chronic Conditions..... | 16 |
| Safety Net Providers | 23 |
| Conclusions..... | 27 |
| Notes..... | 29 |
| Appendix A. Data Tables | 30 |
| Appendix B. Survey Methodology..... | 39 |

LIST OF FIGURES AND TABLES

| | | |
|-------------|--|------|
| Figure ES-1 | Nearly Half of Hispanics and One of Four African Americans Were Uninsured for All or Part of 2006 | x |
| Figure ES-2 | Indicators of a Medical Home | xi |
| Figure ES-3 | Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care..... | xi |
| Figure ES-4 | Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes..... | xii |
| Figure ES-5 | When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits..... | xiii |
| Figure ES-6 | Patients with Medical Homes—Whether Insured or Uninsured— Are Most Likely to Receive Preventive Care Reminders | xiv |
| Figure ES-7 | Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control | xv |
| Figure ES-8 | Indicators of a Medical Home by Usual Health Care Setting | xvi |
| Figure 1 | Nearly Half of Hispanics and One of Four African Americans Were Uninsured for All or Part of 2006 | 3 |
| Figure 2 | Hispanics Are Least Likely to Have Continuous Insurance Coverage Even When a Family Member Has Full-Time Employment..... | 3 |
| Figure 3 | Hispanics and African Americans Are Least Likely to Have Health Insurance Through an Employer..... | 4 |
| Figure 4 | Uninsured Are Less Likely to Report Always Getting the Care They Need When They Need It; Low-Income Adults, When Insured, Are as Satisfied as Higher-Income Adults..... | 5 |
| Figure 5 | When Insured, Minorities Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits; Rates Are Low for All Uninsured Adults, Especially Hispanics..... | 5 |
| Figure 6 | Hispanics Are Most Likely to Be Without a Regular Doctor or Source of Care..... | 7 |
| Figure 7 | Indicators of a Medical Home | 8 |
| Figure 8 | African Americans and Hispanics Are More Likely to Lack a Regular Provider or Source of Care; Hispanics Are Least Likely to Have a Medical Home | 8 |
| Figure 9 | Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care | 9 |

| | | |
|-----------|--|----|
| Figure 10 | The Majority of Adults with a Medical Home Always Get the Care They Need | 10 |
| Figure 11 | Hispanics and Asian Americans Are Less Likely to Report Always Getting Medical Care When Needed | 11 |
| Figure 12 | Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes | 11 |
| Figure 13 | African American and Hispanic Adults Who Have Medical Homes Have Rapid Access to Medical Appointments | 12 |
| Figure 14 | Adults Who Are Sent Reminders Are More Likely to Receive Preventive Screening..... | 13 |
| Figure 15 | Nearly Two-Thirds of Adults with Medical Homes Receive Reminders for Preventive Care | 13 |
| Figure 16 | Hispanics and Asian Americans Are Less Likely to Receive a Reminder for Preventive Care Visits | 14 |
| Figure 17 | When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits..... | 14 |
| Figure 18 | Missed Opportunities for Preventive Care for Adults Who Lack a Regular Source of Care: Just One-Third Had Their Cholesterol Screened | 15 |
| Figure 19 | Hispanics and Asian Americans Are Less Likely to Have Their Cholesterol Checked..... | 16 |
| Figure 20 | African Americans and Hispanics with Medical Homes Are Equally as Likely as Whites to Receive Cholesterol Checks..... | 16 |
| Figure 21 | Only One-Third of Patients with Chronic Conditions Have Medical Homes; Hispanics Are Least Likely to Have a Medical Home | 17 |
| Figure 22 | About Half or More of Hispanics and Asian Americans with Chronic Conditions Were Not Given Plans to Manage Their Condition at Home | 18 |
| Figure 23 | Less than One-Quarter of Adults with Medical Homes Did Not Receive Plans to Manage Their Conditions at Home..... | 19 |
| Figure 24 | Adults With a Medical Home Have Higher Rates of Counseling on Diet and Exercise Even When Uninsured | 19 |
| Figure 25 | Missed Opportunities for Blood Pressure Management Exist Across All Groups, Especially Hispanics..... | 21 |
| Figure 26 | Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control | 21 |

| | | |
|-----------|---|----|
| Figure 27 | Patients with a Medical Home Report Better Coordination Between Their Regular Provider and Specialist..... | 22 |
| Figure 28 | Community Health Centers Serve Large Numbers of Uninsured Adults and Insured Adults with Low Incomes | 24 |
| Figure 29 | Hispanics and African Americans Are More Likely to Rely on Community Health Centers as Their Regular Place of Care..... | 24 |
| Figure 30 | Indicators of a Medical Home by Usual Health Care Setting | 25 |
| Figure 31 | Preventive Care Reminders and Cholesterol Screening Are More Common in Doctors’ Offices, But Community Health Centers Are Not Far Behind..... | 25 |
| Figure 32 | Patients with Medical Homes—Whether Insured or Uninsured— Are Most Likely to Receive Preventive Care Reminders | 26 |
| Figure 33 | Even When Uninsured, Adults with a Medical Home Have Higher Rates of Cholesterol Screening..... | 27 |
| Table 1 | Access to a Medical Home by Race/Ethnicity & Insurance and Poverty Status | 30 |
| Table 2 | Access, Preventive Care, and Physician Counseling by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status..... | 32 |
| Table 3 | Chronic Disease Management and Coordination of Care by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status | 34 |
| Table 4 | Health Status by Race/Ethnicity and Insurance Status | 36 |
| Table 5 | Sociodemographic Characteristics by Race/Ethnicity | 37 |

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Editorial support was provided by Martha Hostetter.

EXECUTIVE SUMMARY

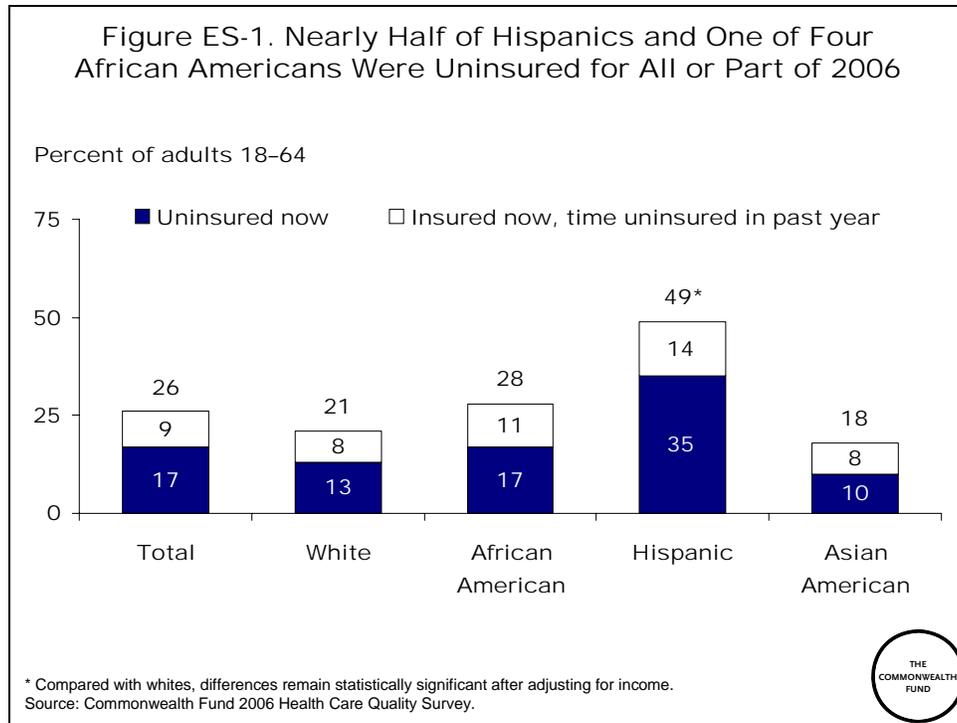
The Commonwealth Fund 2006 Health Care Quality Survey presents new information about interventions that show promise for promoting equity in health care and addressing racial and ethnic disparities in access to high-quality care. Findings from this survey are promising, as they suggest that racial and ethnic disparities are not immutable. Indeed, disparities in terms of access to and quality of care largely disappear when adults have a medical home, insurance coverage, and access to high-quality services and systems of care. The survey finds that, when adults have a medical home, their access to care and rates of preventive screenings improve substantially. Practice systems, in the form of patient reminders, also improve the quality of care for vulnerable patients by promoting higher rates of routine preventive screening.

The Commonwealth Fund Health Care Quality Survey, conducted among adults from May to October 2006, highlights how stable insurance, having a regular provider and, in particular, a medical home, improves health care access and quality among vulnerable populations. Over the past 20 years, much work has been done to identify and develop a set of indicators that best captures the components of a medical home. In this report, a medical home is defined as a health care setting that provides patients with timely, well-organized care and enhanced access to providers. Survey respondents who have a medical home report the following four features: they have a regular provider or place of care; they experience no difficulty contacting their provider by phone; they experience no difficulty getting care or advice on weekends or evenings; and they report that their office visits are always well organized and on schedule.

Following are some of the key findings of the survey.

Hispanics and African Americans are vulnerable: their uninsured rates are higher and they are less likely than whites to have access to a regular doctor or source of care.

- Among adults ages 18 to 64, nearly half of Hispanics (49%) and more than one of four African Americans (28%) were uninsured during 2006, compared with 21 percent of whites and 18 percent of Asian Americans (Figure ES-1).
- Hispanics and African Americans also have differential access to a regular doctor or source of care, with Hispanics particularly at risk. As many as 43 percent of Hispanics and 21 percent of African Americans report they have no regular doctor or source of care, compared with 15 percent of whites and 16 percent of Asian Americans.



By definition, a medical home provides patients with enhanced access to providers and timely, organized care.

- Only 27 percent of adults ages 18 to 64 reported having all four indicators of a medical home: a regular doctor or source of care; no difficulty contacting their provider by telephone; no difficulty getting care or medical advice on weekends or evenings; and doctors' visits that are well organized and running on time (Figure ES-2).
- Many providers do not offer medical care or advice during evenings or weekends. Only two-thirds of adults who have a regular provider or source of care say that it is easy to get care or advice after hours. Compared with other populations, Hispanics are least likely to have access to after-hours care.
- Among adults who have a regular doctor or source of care, African Americans are most likely to have a medical home that provides enhanced access to physicians and well-organized care. One-third of African Americans (34%) have a medical home, compared with 28 percent of whites, 26 percent of Asian Americans, and just 15 percent of Hispanics.
- The uninsured are the least likely to have a medical home. Only 16 percent of the uninsured receive care through a medical home; 45 percent do not have a regular source of care (Figure ES-3).

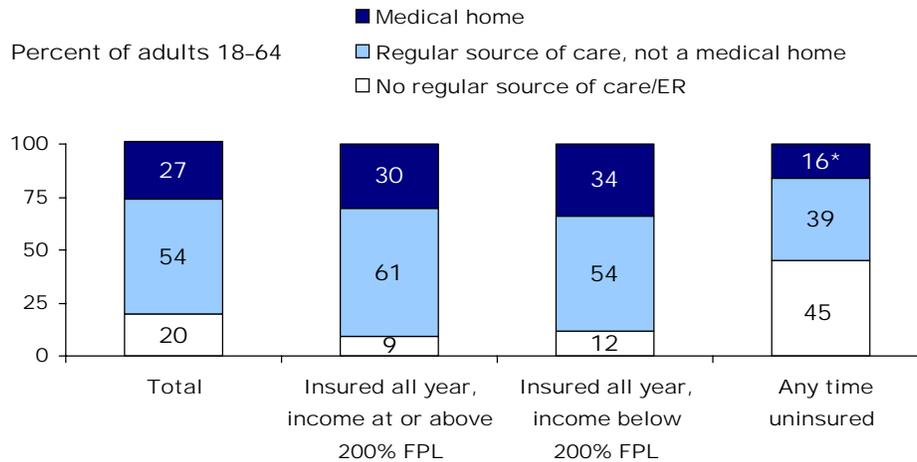
Figure ES-2. Indicators of a Medical Home
(adults 18-64)

| Indicator | Total | | Percent by Race | | | |
|---|--------------------|---------|-----------------|------------------|----------|----------------|
| | Estimated millions | Percent | White | African American | Hispanic | Asian American |
| Regular doctor or source of care | 142 | 80 | 85 | 79 | 57 | 84 |
| <i>Among those with a regular doctor or source of care . . .</i> | | | | | | |
| Not difficult to contact provider over telephone | 121 | 85 | 88 | 82 | 76 | 84 |
| Not difficult to get care or medical advice after hours | 92 | 65 | 65 | 69 | 60 | 66 |
| Doctors' office visits are always or often well organized and running on time | 93 | 66 | 68 | 65 | 60 | 62 |
| All four indicators of medical home | 47 | 27 | 28 | 34 | 15 | 26 |

Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure ES-3. Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care

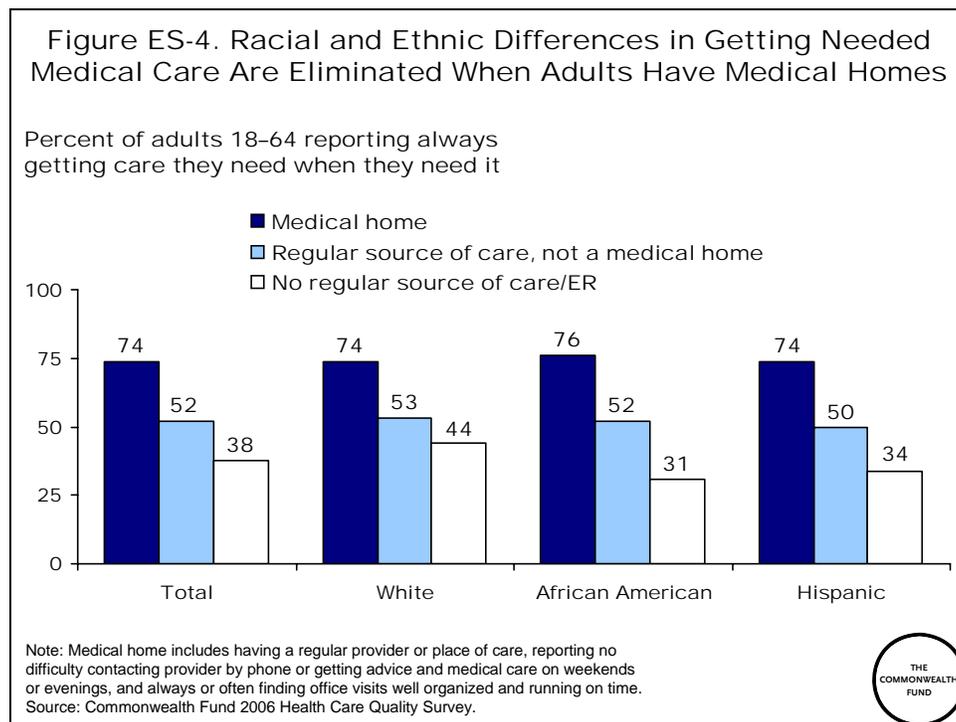


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with insured with income at or above 200% FPL, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Medical homes reduce disparities in access to care.

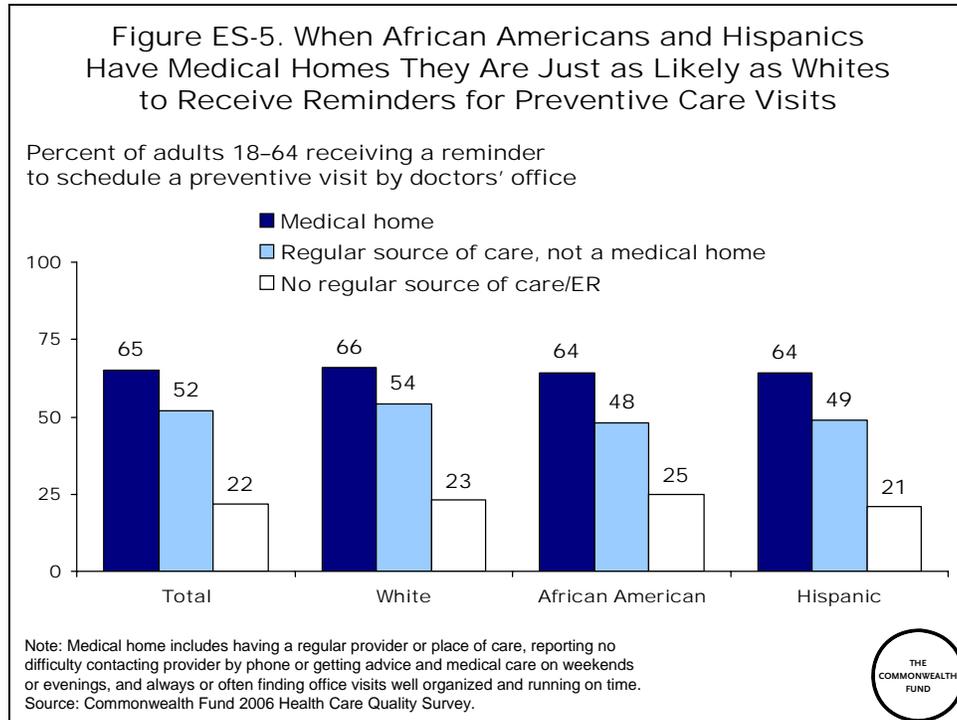
- The vast majority (74%) of adults with a medical home always get the care they need, compared with only 52 percent of those with a regular provider that is not a medical home and 38 percent of adults without any regular source of care or provider.
- When minorities have a medical home, racial and ethnic differences in terms of access to medical care disappear. Three-fourths of whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it (Figure ES-4).



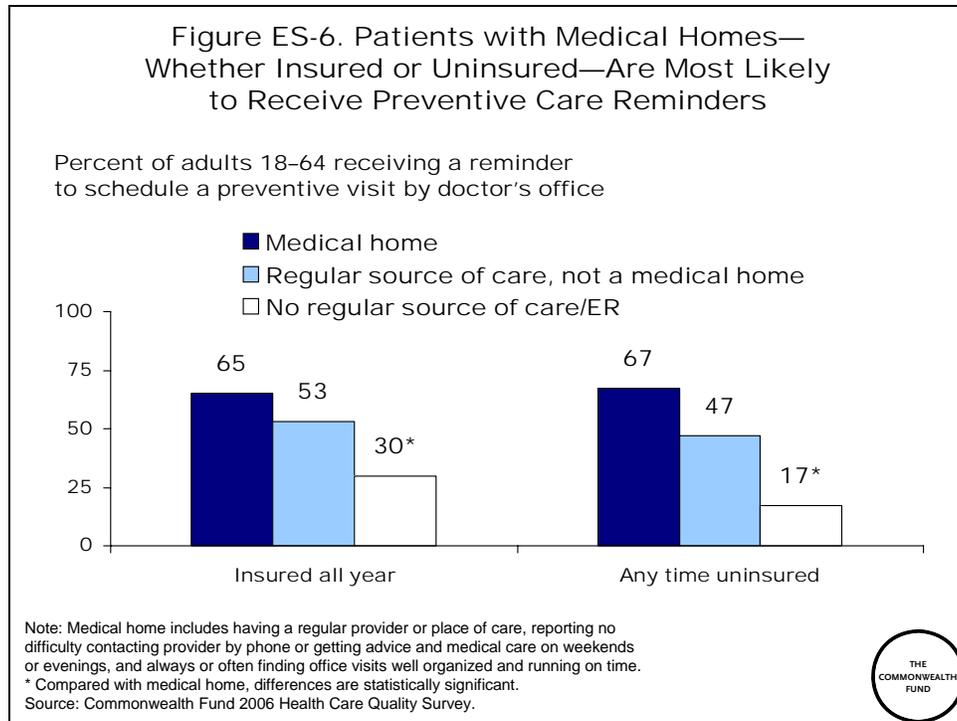
Use of reminders for preventive care is associated with higher rates of preventive screening. Among patients with medical homes, there are no racial disparities in terms of receipt of preventive care reminders.

- The use of reminders substantially increases the rates of routine preventive screenings, such as cholesterol screening, breast cancer screening, and prostate cancer screening. Eight of 10 (82%) adults who received a reminder had their cholesterol checked in the past five years, compared with half of adults who did not get a reminder.
- Men who received a reminder were screened for prostate cancer at twice the rate (70%) as those who did not get a reminder (37%).

- When minorities have a medical home, their access to preventive care improves substantially. Regardless of race or ethnicity, about two-thirds of all adults who have a medical home receive preventive care reminders (Figure ES-5).

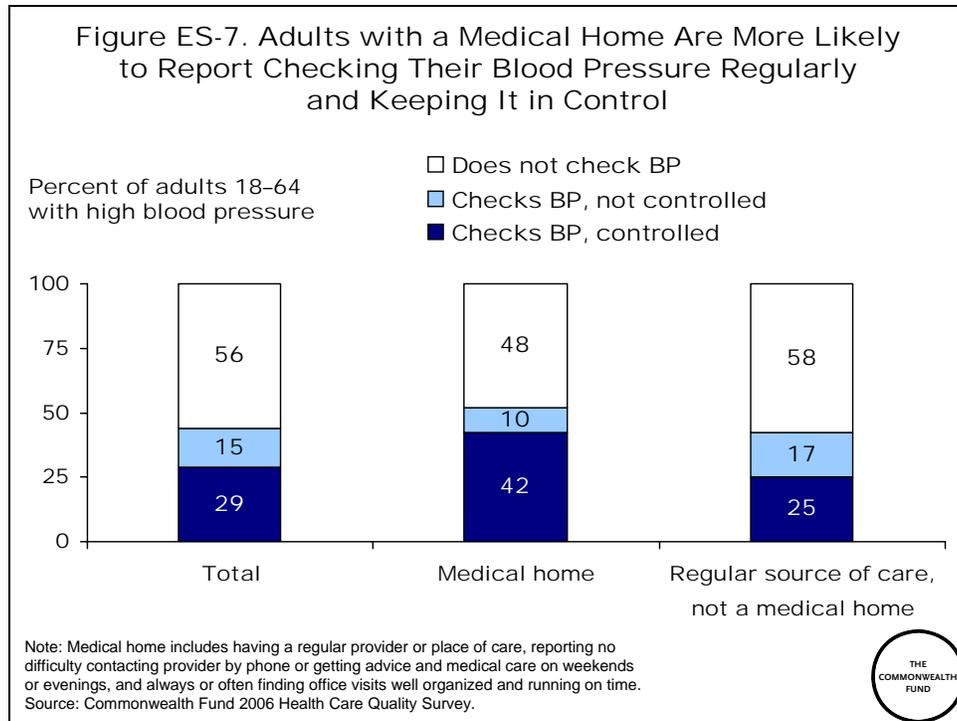


- More than half of insured adults (54%) received a reminder from a doctors' office to schedule a preventive visit, compared with only 36 percent of uninsured adults. When minority populations are insured, they are just as likely as white adults to receive reminders to schedule preventive care.
- Even among the uninsured, having a medical home affects whether patients receive preventive care reminders. Two-thirds of both insured and uninsured adults with medical homes receive preventive care reminders, compared with half of insured and uninsured adults without medical homes (Figure ES-6).



Adults with medical homes are better prepared to manage their chronic conditions—and have better health outcomes—than those who lack medical homes.

- The survey finds that adults who have medical homes are better prepared to manage their chronic conditions. Only 23 percent of adults with a medical home report their doctor or doctor's office did not give them a plan to manage their care at home, compared with 65 percent of adults who lack a regular source of care.
- Among hypertensive adults, 42 percent of those with a medical home reported that they regularly check their blood pressure and that it is well controlled. Only 25 percent of hypertensive adults with a regular source of care, but not a medical home, reported this (Figure ES-7).
- Adults with a medical home reported better coordination between their regular providers and specialists. Among those who saw a specialist, three-fourths said their regular doctor helped them decide whom to see and communicated with the specialist about their medical history, compared with 58 percent of adults without a medical home.



Community health centers and public clinics—which care for many uninsured, low-income, and minority adults—are less likely than private doctors’ offices to have features of a medical home.

- The survey finds that community health centers or public clinics serve 20 percent of the uninsured and 20 percent of low-income adults with coverage. In addition, 13 percent of African Americans and more than one of five Hispanics named community health centers or public clinics as their regular source of care.
- Patients who use community health centers or public clinics as their usual source of care are less likely than those who use private doctors’ offices to have a medical home. Only 21 percent of adults using community health centers or public clinics reported that they have a regular doctor, have no difficulty contacting their provider by telephone or getting care or medical advice on weekends or evenings, and reported that their doctors’ visits are always well organized and running on time. In contrast, 32 percent of patients who use private doctors’ offices reported all features of a medical home. Difficulty getting medical advice or care in the evenings or on weekends is more pervasive in community health centers and public clinics than in private doctors’ offices or clinics (Figure ES-8).

Figure ES-8. Indicators of a Medical Home
by Usual Health Care Setting
(adults 18-64)

| Indicator | Total | Usual Health Care Setting | | |
|---|-------|---------------------------|--|-----------------|
| | | Doctors' office | Community health center or public clinic | Other settings* |
| Regular doctor or source of care | 80% | 95% | 78% | 63% |
| <i>Among those with a regular doctor or source of care . . .</i> | | | | |
| Not difficult to contact provider over telephone | 85 | 87 | 77 | 77 |
| Not difficult to get care or medical advice after hours | 65 | 67 | 54 | 69 |
| Always or often find visits to doctors' office well organized and running on time | 66 | 68 | 56 | 60 |
| All four indicators of a medical home | 27 | 32 | 21 | 22 |

* Includes hospital outpatient departments and other settings.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



CONCLUSIONS

The Commonwealth Fund Health Care Quality Survey finds that, when patients have a medical home, racial and ethnic disparities in terms of access to and quality of care are reduced or eliminated. The survey results suggest that all providers should take steps to help create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes, as they care for patients regardless of ability to pay. Improving the quality of health care delivered by safety net providers can have a significant impact on disparities by promoting equity and ensuring access to high-quality care.

In addition, the promotion of medical homes, including the establishment of standards, public reporting of performance, and rewards for achieving excellence, would support improvement in the delivery of health care services in all settings.

CLOSING THE DIVIDE: HOW MEDICAL HOMES PROMOTE EQUITY IN HEALTH CARE

INTRODUCTION: THE IMPORTANCE OF HAVING INSURANCE COVERAGE AND A MEDICAL HOME

Racial and ethnic minorities are more likely than whites to have low incomes and be in poor health. Lack of health insurance and lack of access to a regular source of care are key contributors to racial and ethnic health care disparities.¹ Previous Fund reports have demonstrated that uninsured rates for Hispanic and African American adults are one-and-a-half to three times greater than the rate for white adults.² In addition, Hispanics are particularly disconnected from the health care system, being substantially less likely than whites to have a regular doctor, to have visited a doctor in the past year, or to feel confident about their ability to manage their health problems. African Americans also have more problems with access to care and are significantly more likely than whites to visit the emergency room for non-urgent care and to experience serious problems dealing with medical bills and medical debt.³

Yet, even when minority adults have access to the health care system, they receive lower-quality care for many conditions and report receiving less respect for their personal preferences, compared with white patients.⁴

“Medical homes” are one model for expanding access and delivering high-quality care. A medical home is more than just a regular place to receive health care; it is a comprehensive approach to providing accessible, organized primary care. The concept of a medical home was first introduced by the American Academy of Pediatrics and has been described as a place where health care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.⁵ In medical home practices, patients develop relationships with their providers and work with them to maintain a healthy lifestyle and coordinate preventive and ongoing health services.⁶ Over the past 20 years, much work has been done to identify and develop a set of indicators that captures the components of a medical home.⁷

The Commonwealth Fund 2006 Health Care Quality Survey finds that health care settings with features of a medical home—those that offer patients a regular source of care, enhanced access to physicians, and timely, well-organized care—have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities. This suggests that expanding access to medical homes could improve quality and increase equity in the health care system.

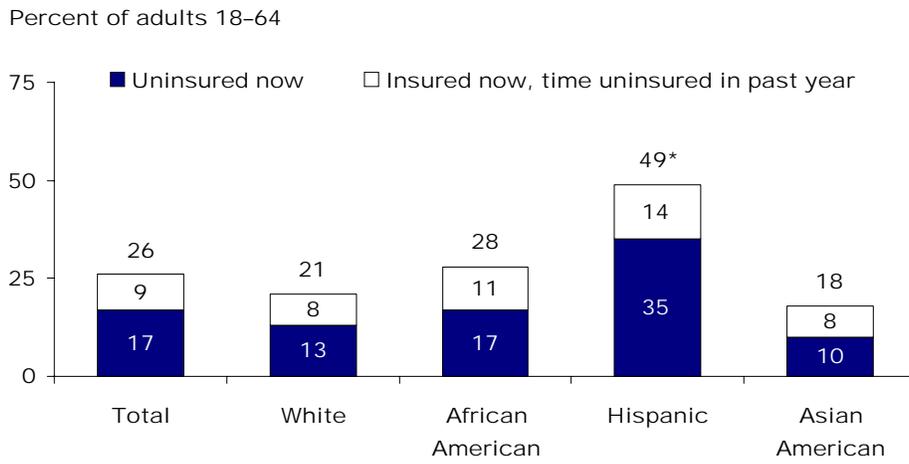
The survey was conducted among a random, nationally representative sample of 3,535 adults age 18 and older living in the continental United States. This report is based on analysis of responses from non-elderly adults ages 18 to 64; respondents are classified by whether they have a regular doctor or place of care, whether their place of care is a medical home, or whether they have neither a medical home nor a regular place of care. Where the sample size permits, the analysis highlights differences in outcomes by racial and ethnic groups as well as by insurance and poverty status (see [Appendix B. Survey Methodology](#) for more detail).

INSURANCE COVERAGE AMONG AFRICAN AMERICAN AND HISPANIC ADULTS

Uninsured rates in 2006 remained high for African Americans and Hispanics.

Among working-age adults ages 18 to 64, nearly half of Hispanics (49%) and 28 percent of African Americans were uninsured during the year, compared with 21 percent of whites and 18 percent of Asian Americans (Figure 1). African Americans and Hispanics are more likely than whites and Asian Americans to be uninsured, in large part because they are less likely to get coverage through their employers. Indeed, although most African Americans and Hispanics live in families in which at least one member is working, rates of continuous health coverage are lower for these minority groups, particularly for Hispanics. Only about half of Hispanics (53%) in families with at least one full-time worker were insured all year, compared with 82 percent of whites and 75 percent of African Americans (Figure 2). Just 43 percent of working-age Hispanics and 54 percent of African Americans have employer-based insurance, compared with 68 percent of whites and 71 percent of Asian Americans (Figure 3).

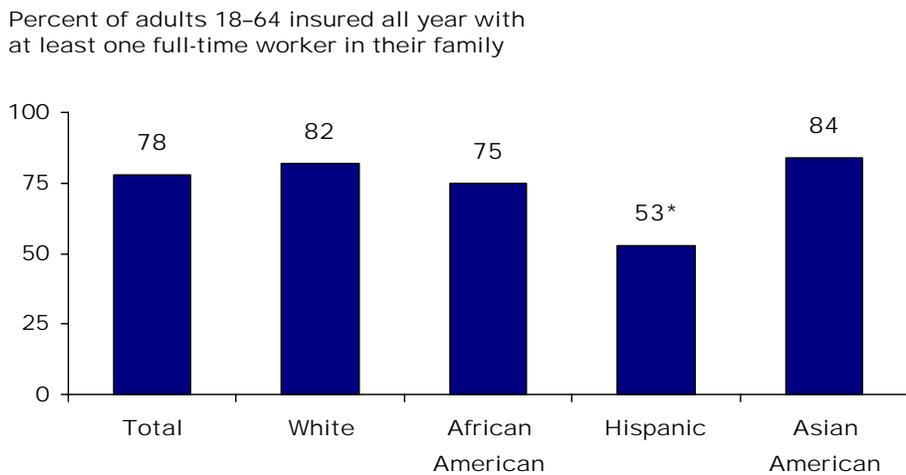
Figure 1. Nearly Half of Hispanics and One of Four African Americans Were Uninsured for All or Part of 2006



* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

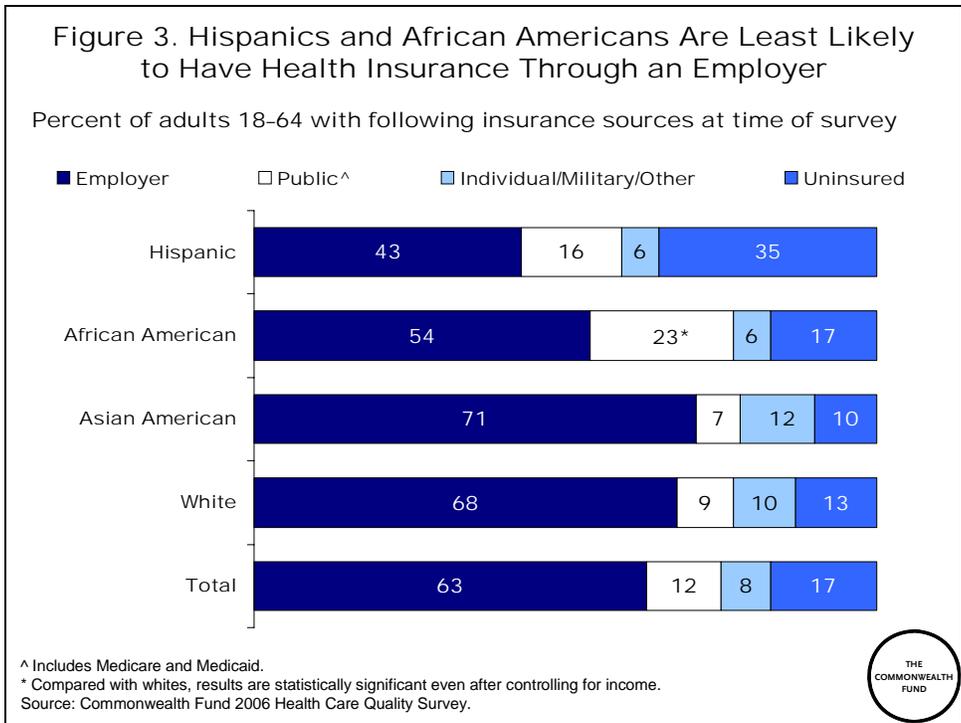


Figure 2. Hispanics Are Least Likely to Have Continuous Insurance Coverage Even When a Family Member Has Full-Time Employment



* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



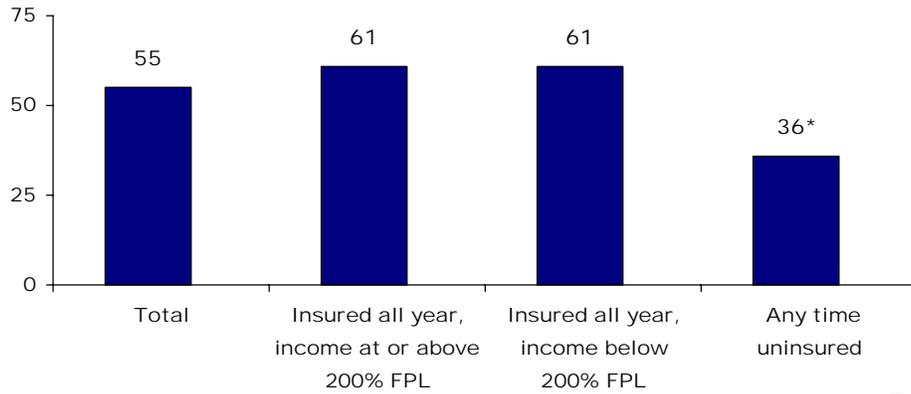


Insurance coverage reduces disparities among low-income and minority adults. Lack of insurance coverage is a persistent problem for low-income adults as well as racial and ethnic minorities, and health insurance is a critical factor in determining whether people have timely access to appropriate care across a range of preventive, chronic, and acute care services. Sixty-one percent of insured adults reported being able to get the care they need, compared with 36 percent of uninsured adults (Figure 4).

Building on previous research demonstrating the role of health insurance in facilitating access to timely care, this survey finds that expanding coverage would benefit the most vulnerable populations; in fact, some disparities in health care access and utilization could be reduced or even eliminated.⁸ Survey findings indicate that, when minority populations are insured, they are just as likely as white adults to receive many important preventive care interventions. For example, more than half of insured adults (54%) receive a reminder from a doctors' office to schedule preventive visits, compared with only 36 percent of uninsured adults. When insured, minorities receive preventive care reminders at similar rates as whites (Figure 5).

Figure 4. Uninsured Are Less Likely to Report Always Getting the Care They Need When They Need It; Low-Income Adults, When Insured, Are as Satisfied as Higher-Income Adults

Percent of adults 18-64 reporting always getting care they need when they need it

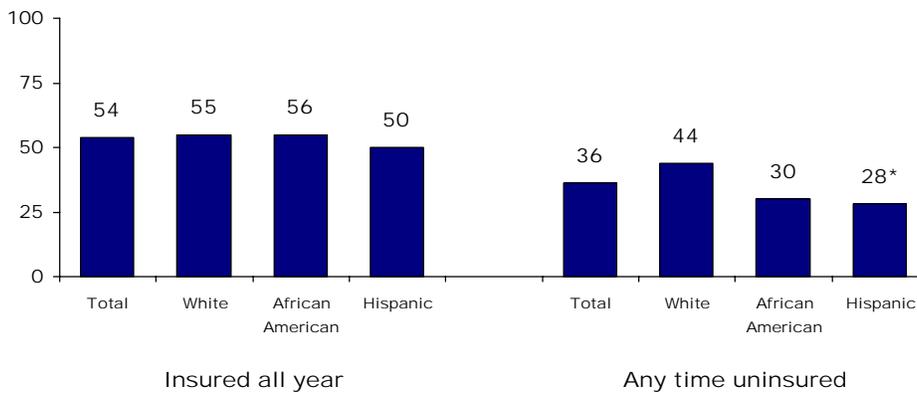


* Compared with insured with income at/above 200% poverty, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure 5. When Insured, Minorities Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits; Rates Are Low for All Uninsured Adults, Especially Hispanics

Percent of adults 18-64 receiving a reminder to schedule a preventive visit by doctor's office



* Compared with whites, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



ACCESS TO A MEDICAL HOME

Hispanics and African Americans are more likely to be uninsured—and to lack access to a medical home. Just as Hispanics and African Americans are more likely than whites and Asian Americans to lack health coverage, they also are more likely to lack access to a regular doctor or source of care. Hispanics are particularly at risk. As many as 43 percent of Hispanics and 21 percent of African Americans reported they have no regular doctor or source of care, compared with 15 percent of whites and 16 percent Asian Americans (Figure 6).

Beyond basic access to a regular provider, the survey studied the impact of having access to an enhanced regular provider—that is, access to a medical home. The survey used the following four indicators to measure the extent to which adults have a medical home: 1) having a regular doctor or place of care, 2) experiencing no difficulty contacting their provider by telephone; 3) experiencing no difficulty getting care or medical advice on weekends or evenings; and 4) having doctors' office visits that are well organized and running on time (Figure 7).

By definition, a medical home provides patients with better access to physicians and well-organized care. The majority of respondents who have a regular source of care can contact their providers by phone. Yet, many providers do not offer medical care or advice during evenings or weekends. Only two-thirds of adults (65%) who have a regular provider or source of care reported that it is easy to get care or medical advice after hours. Among patient groups, Hispanics are least likely to be able to get care or advice after hours and African Americans are the most likely to be able to do so. Another 66 percent of adults with a regular provider or source of care reported that their doctor visits are always or often organized and running on time, with white adults the most likely to have reported this and Hispanics and Asian Americans the least likely.

When all four characteristics of a medical home are combined, only 27 percent of working-age adults—an estimated 47 million people—have a medical home (Figure 8). Another 54 percent of adults have a regular doctor or source of care, but they do not have the enhanced access to care provided by a medical home. The remaining 20 percent of adults have no regular doctor or source of care. Among patient groups, African Americans are most likely and Hispanics are least likely to have a medical home that provides enhanced access to physicians and well-organized care. One-third of African Americans (34%) have a medical home, compared with 28 percent of whites, 26 percent of Asian Americans, and just 15 percent of Hispanics.

Having insurance coverage is a strong predictor of whether adults have a medical home or a regular source of care (Figure 8). Only 16 percent of adults who were uninsured during the year have a medical home. By comparison, 30 percent of insured adults with incomes twice the poverty level or higher, and an even greater proportion of insured, low-income adults (34%), have a medical home (Figure 9). Most vulnerable are the 45 percent of uninsured adults—an estimated 21 million people—who do not have a regular source of care. There are also a fair number of uninsured adults (39%) who have a regular source of care, but nonetheless lack the enhanced access to providers available in a medical home. Among this group of uninsured patients, nearly one of three (28%) uses community health centers or public clinics and 61 percent use doctors' offices for their care (data not shown).

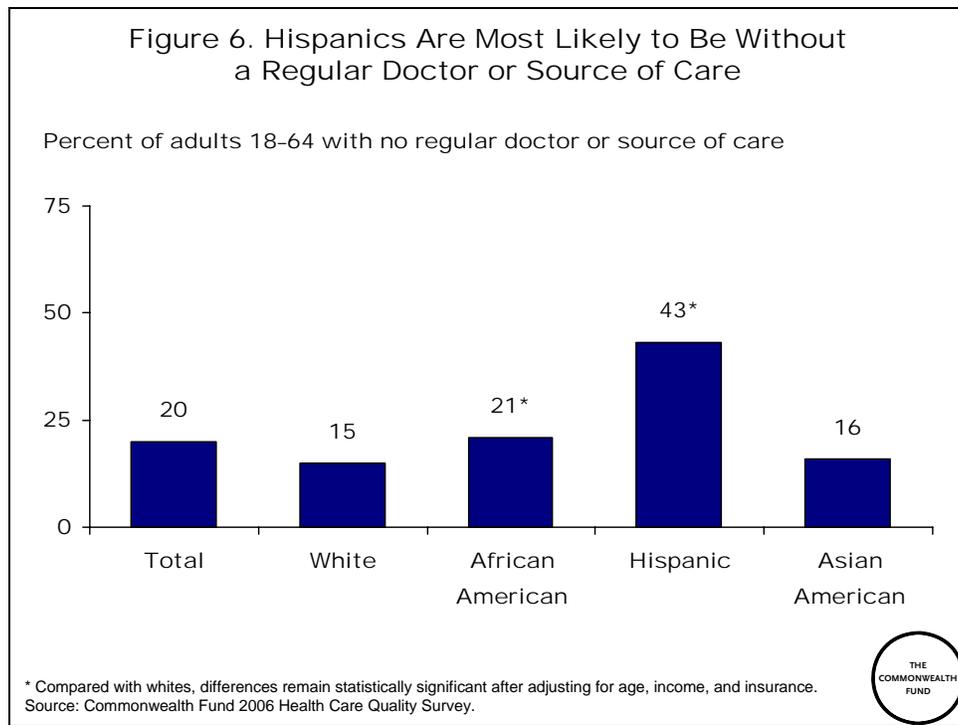


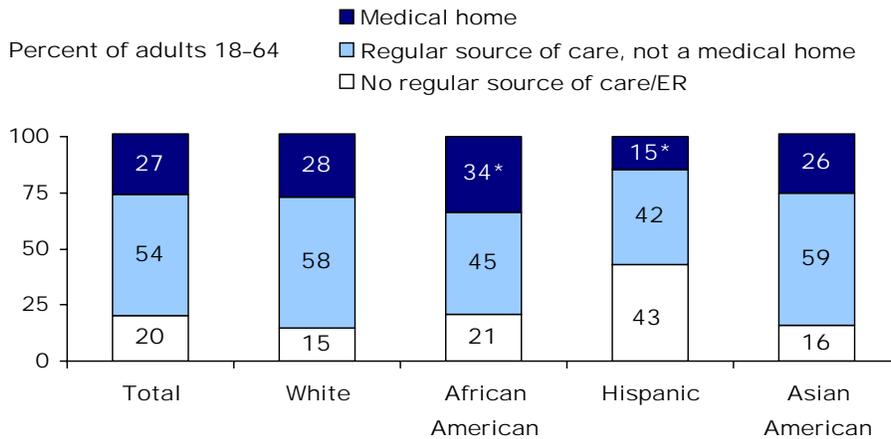
Figure 7. Indicators of a Medical Home
(adults 18-64)

| Indicator | Total | | Percent by Race | | | |
|---|--------------------|---------|-----------------|------------------|----------|----------------|
| | Estimated millions | Percent | White | African American | Hispanic | Asian American |
| Regular doctor or source of care | 142 | 80 | 85 | 79 | 57 | 84 |
| <i>Among those with a regular doctor or source of care . . .</i> | | | | | | |
| Not difficult to contact provider over telephone | 121 | 85 | 88 | 82 | 76 | 84 |
| Not difficult to get care or medical advice after hours | 92 | 65 | 65 | 69 | 60 | 66 |
| Doctors' office visits are always or often well organized and running on time | 93 | 66 | 68 | 65 | 60 | 62 |
| All four indicators of medical home | 47 | 27 | 28 | 34 | 15 | 26 |

Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure 8. African Americans and Hispanics Are More Likely to Lack a Regular Provider or Source of Care; Hispanics Are Least Likely to Have a Medical Home

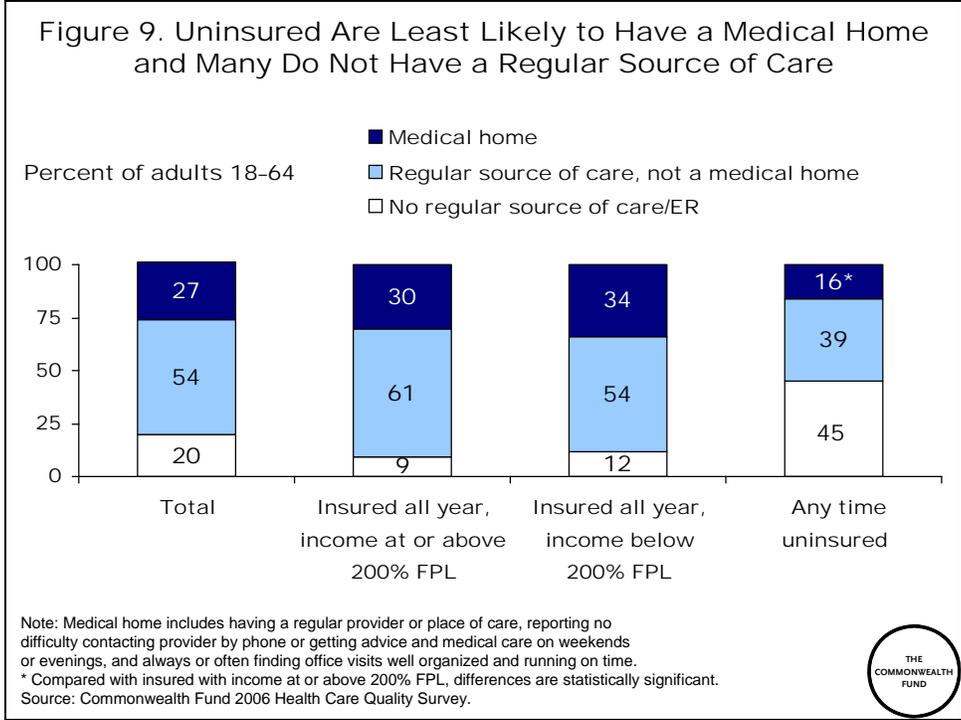


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

* Compared with whites, differences remain statistically significant after adjusting for income and insurance.

Source: Commonwealth Fund 2006 Health Care Quality Survey.





TIMELY RECEIPT OF NEEDED CARE AND PREVENTIVE SERVICES

Asian Americans and Hispanics have more difficulty accessing timely and needed care. The survey asked respondents to rate their ability to get needed medical care. Specifically, respondents were asked, “When you think about your health care in general, how often do you receive the health care you need when you need it?”⁹ Findings show that just over half of adults (55%) said they always get the care they need (Table 2). Asian Americans and Hispanics were least likely to have reported always being able to get needed care: less than half of Hispanics (46%) and Asian Americans (48%) reported this, compared with 57 percent of whites and 56 percent of African Americans. Waiting times to get medical appointments also differ significantly by race/ethnicity. Hispanic and Asian Americans were less likely to report rapid access to medical appointments (i.e., same- or next-day appointments) and more likely to report waits of six days or more (Table 2). Over one-quarter (26%) of Hispanics and 18 percent of Asian Americans had to wait six days or longer to get a medical appointment, compared with 14 percent of whites.

Medical homes eliminate racial and ethnic differences in receipt of timely medical care. Whether adults have medical homes significantly affects whether they can get the care they need, when they need it. Moreover, racial and ethnic differences in terms of timely access to care are eliminated when adults have medical homes. The vast majority (74%) of adults with a medical home reported always getting the

care they need, compared with only 52 percent of adults who have a regular provider but not a medical home and just 38 percent of adults without any regular source of care or provider (Figure 10). Minorities, particularly Hispanics and Asian Americans, were less likely to report always getting the care they need (Figure 11). However, when minorities have a medical home, they are as likely as whites to get the care they need and have rapid access to medical appointments. Three-fourths of whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it (Figure 12).

Adults who do not have a medical home are at a significant disadvantage when seeking rapid access to medical appointments. The vast majority of adults with a medical home (76%) can get same- or next-day appointments, whereas only 62 percent of those who have a regular provider but not a medical home and 43 percent of those without any regular provider can do so. Indeed, no racial or ethnic disparities remain in terms of rapid access to medical appointments among adults with medical homes (Figure 13). Regardless of race or ethnicity, three-fourths of all adults with a medical home have rapid access to medical appointments. Among adults with no regular source of care, there are no differences among patient groups in terms of the ability to get same- or next-day appointments.

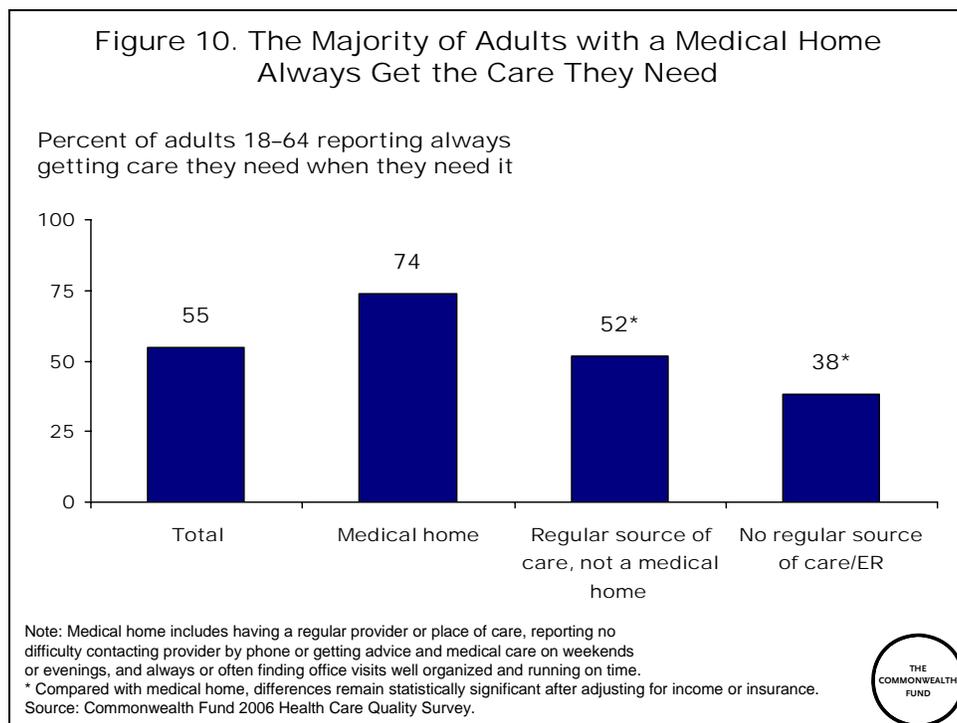
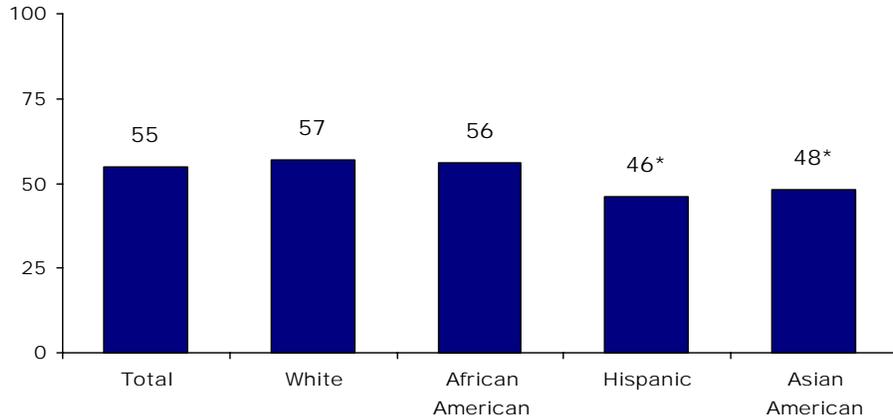


Figure 11. Hispanics and Asian Americans Are Less Likely to Report Always Getting Medical Care When Needed

Percent of adults 18-64 reporting always getting care they need when they need it

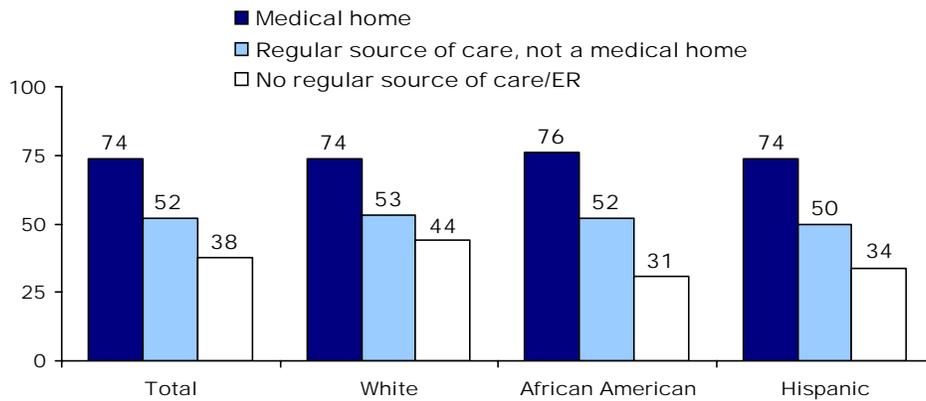


* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



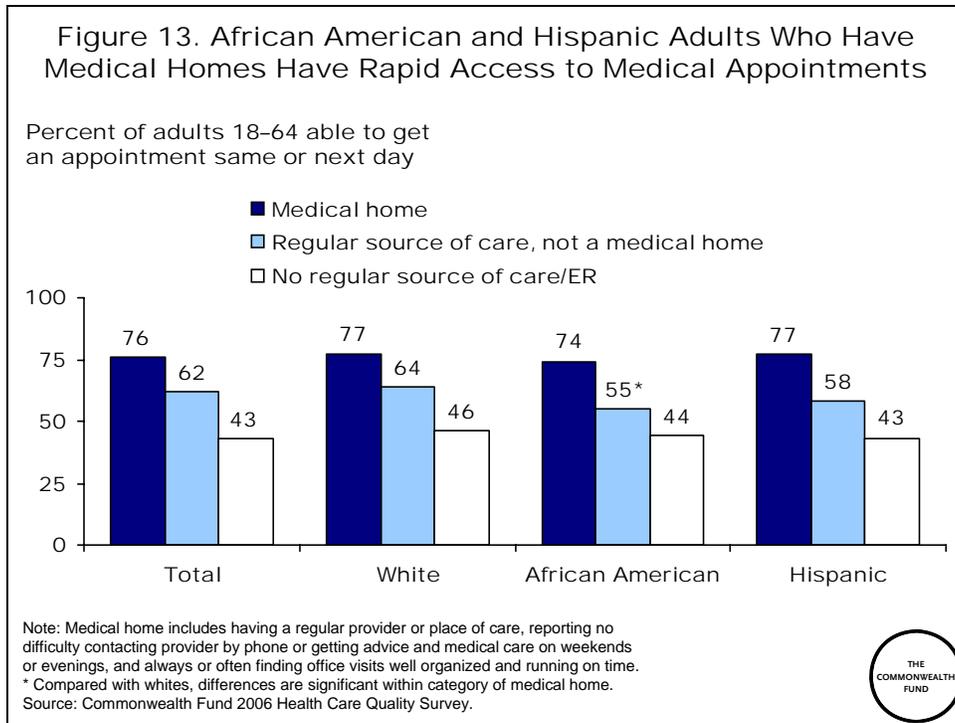
Figure 12. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18-64 reporting always getting care they need when they need it



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.





Reminders sent by doctors are associated with higher rates of routine preventive care; medical homes are more likely to send reminders. Providers can encourage patients to seek routine preventive care by sending them reminders to make appointments for preventive care visits. The survey findings show that preventive care reminders are associated with substantially higher rates of routine preventive screening. For example, adults who receive reminders have significantly higher rates of cholesterol screenings than those who do not receive reminders (82% vs. 50%). A similar pattern is evident for breast cancer screening (79% vs. 62%) and prostate cancer screening (70% vs. 37%) (Figure 14).

The survey finds that adults who have a medical home are significantly more likely to receive reminders from their doctor and get recommended preventive screening. Nearly two-thirds of adults with a medical home receive reminders for preventive care, but just half of adults (52%) with a regular provider that is not a medical home, and only 22 percent of adults without a regular source of care, receive such reminders (Figure 15). About half of all adults receive preventive care reminders from their providers. Yet, just 39 percent of Hispanics and 37 percent of Asian Americans receive such reminders, compared with about half of African American (49%) and white (53%) adults (Figure 16). Yet, when they have a medical home, minorities are just as likely as whites to receive reminders for preventive care visits (Figure 17).

Figure 14. Adults Who Are Sent Reminders Are More Likely to Receive Preventive Screening

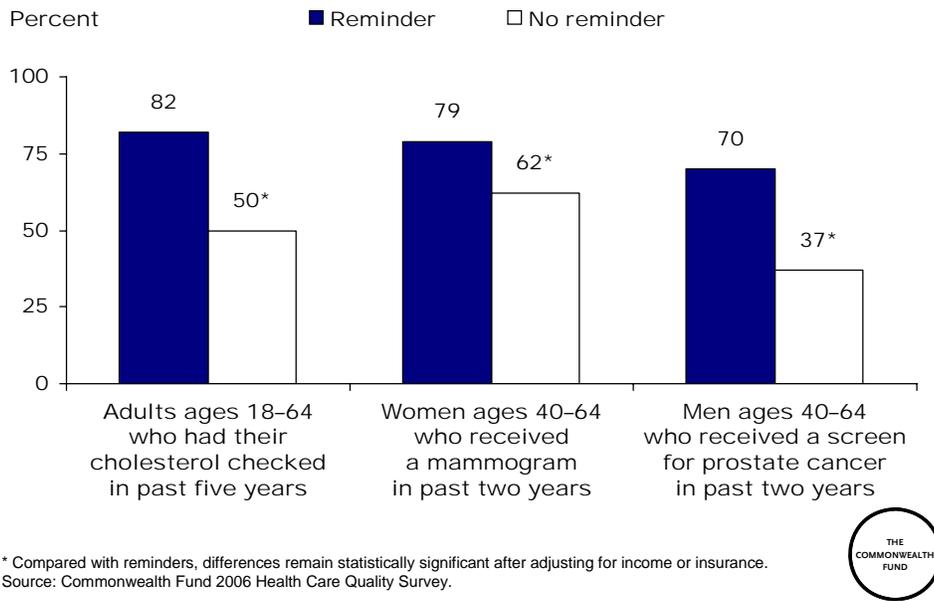


Figure 15. Nearly Two-Thirds of Adults with Medical Homes Receive Reminders for Preventive Care

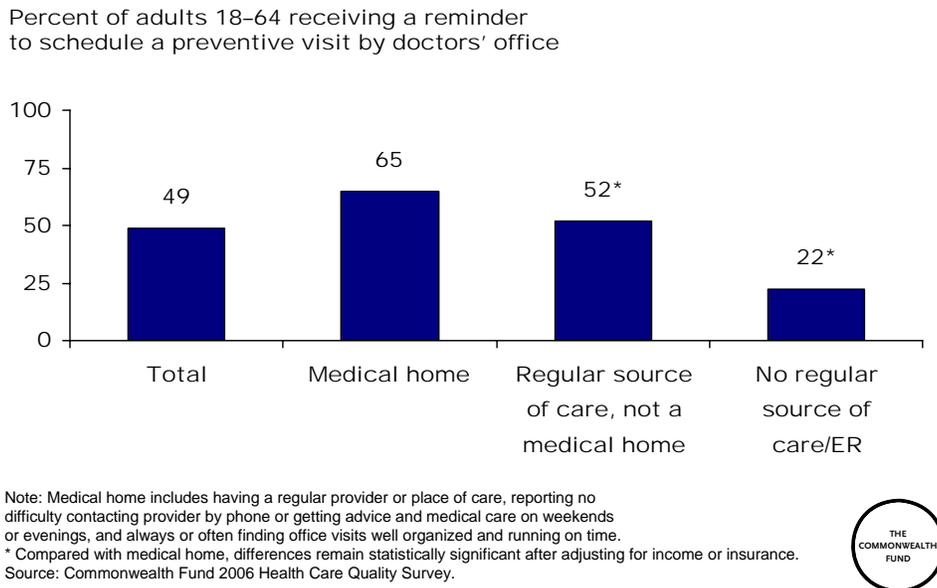
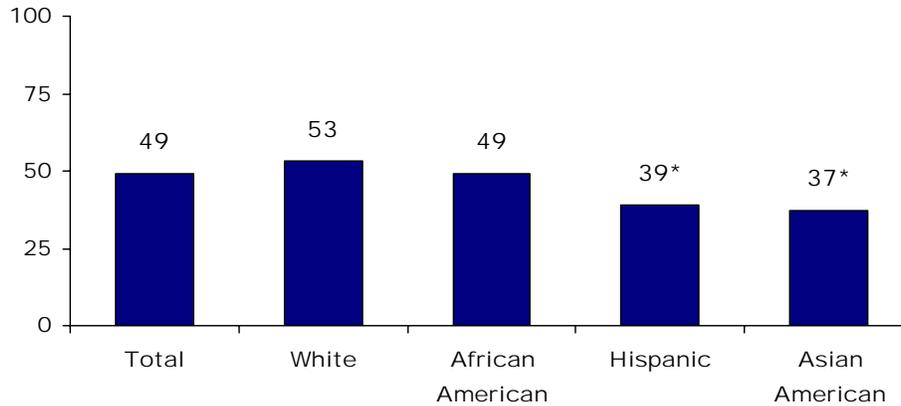


Figure 16. Hispanics and Asian Americans Are Less Likely to Receive a Reminder for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office

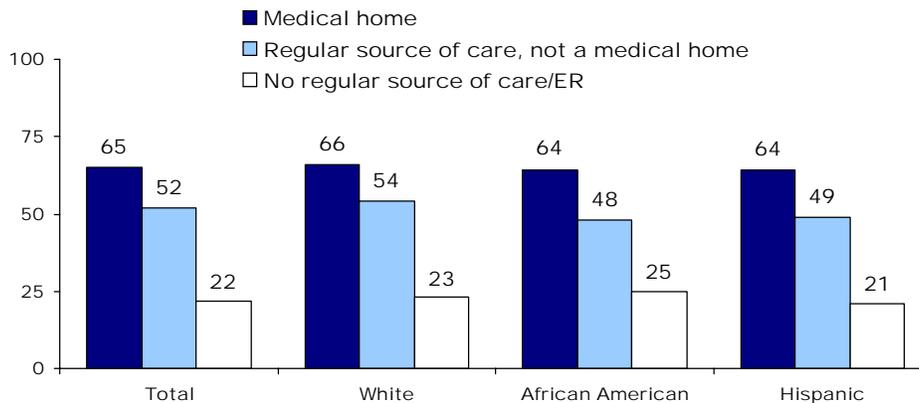


* Compared with whites, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure 17. When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



When minorities have medical homes, their use of preventive care increases and disparities narrow. Adults with no regular provider or source of care are at great risk for not getting recommended preventive tests. The majority of adults (76%) with a medical home reported getting their cholesterol checked in the past five years,

compared with only one-third (34%) of adults without a regular provider or source of care (Figure 18). Those with a medical home also reported higher rates of prostate cancer screening: nearly four of five (77%) men with a medical home were screened for prostate cancer, compared with only 47 percent of men who have a regular provider but not a medical home and 34 percent of men without a regular provider or source of care (Table 2). Clearly, adults who do not have a medical home or lack a regular source of care are at a great disadvantage when it comes to receiving optimal preventive care.

Rates of receipt of preventive care reminders, as well as preventive services such as cholesterol and cancer screening, are particularly low among Hispanics. Slightly more than half (56%) of Hispanics reported having their cholesterol checked in the past five years, compared with 67 percent of whites, 63 percent of African Americans, and 62 percent of Asian Americans (Figure 19). Prostate cancer screening rates are even lower—just two of five (39%) Hispanic men were screened for prostate cancer, compared with half or more of white, African American, and Asian American men (Table 2). When Hispanics have a medical home, their access to preventive care improves substantially, and these disparities are reduced or eliminated. Indeed, regardless of race or ethnicity, cholesterol screening rates improve for all adults with a medical home. In fact, when Hispanic adults have a medical home, they are just as likely as white adults to have their cholesterol screened (Figure 20). Three of four (75%) whites with a medical home had a cholesterol screening, as did 73 percent of African Americans and 69 percent of Hispanics with medical homes.

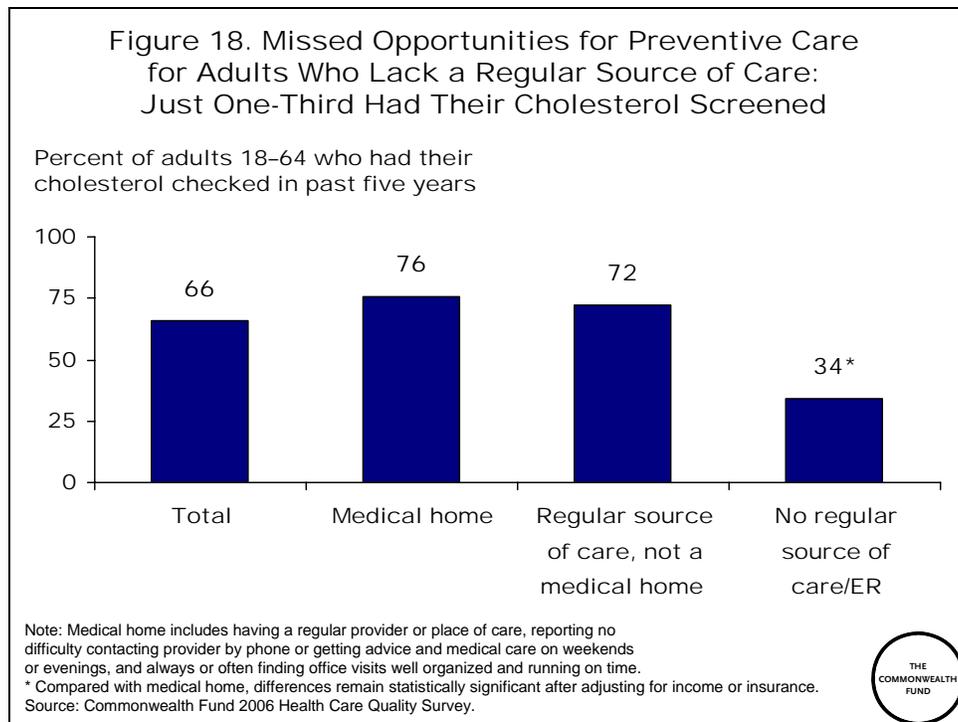
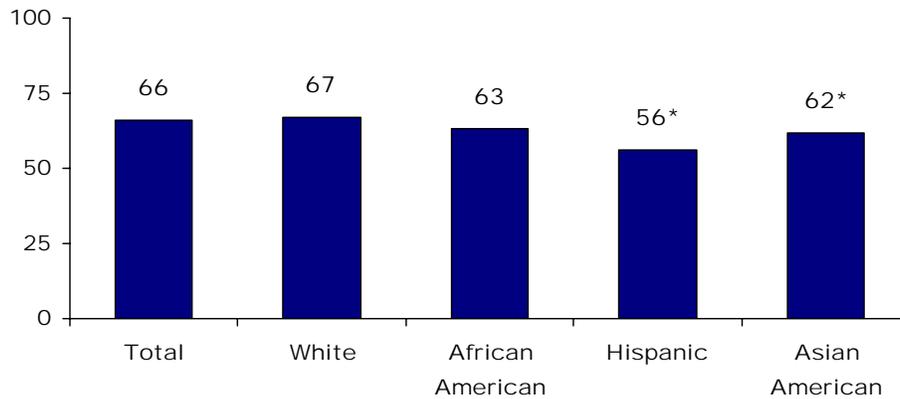


Figure 19. Hispanics and Asian Americans Are Less Likely to Have Their Cholesterol Checked

Percent of adults 18-64 who had their cholesterol checked in past five years

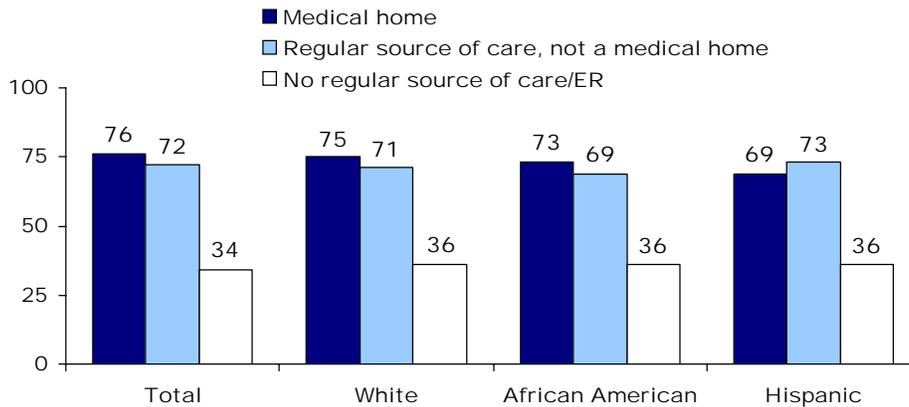


* Compared with whites, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure 20. African Americans and Hispanics with Medical Homes Are Equally as Likely as Whites to Receive Cholesterol Checks

Percent of adults 18-64 who had their cholesterol checked in past five years



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

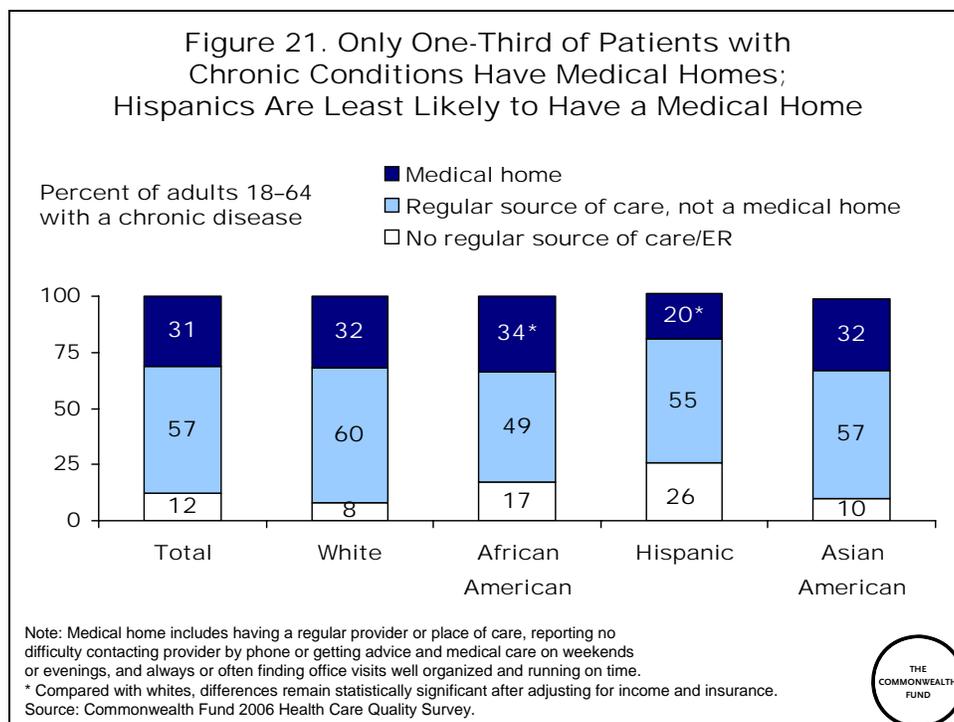


MANAGEMENT OF CHRONIC CONDITIONS

Prevalence of chronic conditions and access to a medical home. To be effective, a health system needs to be able to manage care for patients with chronic medical conditions. The survey finds that, among patient groups, African Americans have the

highest prevalence of chronic conditions, including high blood pressure, diabetes, asthma or emphysema, and heart disease. Forty-three percent of African Americans have at least one chronic condition, compared with 35 percent of whites, 24 percent of Hispanics, and 22 percent of Asian Americans (Table 4). Among all populations, an estimated 59.5 million working-age adults have medical needs, or chronic conditions, that require continuous access to high-quality health systems.

For patients, successfully managing a chronic condition requires an ongoing relationship with a medical provider who can partner with them and coordinate their care. Many chronic conditions, such as diabetes and hypertension, require a great deal of management through diet, exercise, and monitoring. However, among all adults with a chronic condition, less than one-third reported having a medical home to support them in management of their conditions. The survey uncovered racial differences on this measure: among those with chronic conditions, Hispanics are the least likely to have medical homes (20%) compared with whites (32%), Asian Americans (32%), and African Americans (34%) (Figure 21).



Hispanics and Asian Americans with chronic conditions are least likely to be given adequate support to manage their conditions. The survey finds that more than one of three adults with chronic conditions are not given adequate support to manage their conditions. Over half (54%) of Asian Americans and 48 percent of Hispanics reported they were not given a plan to manage their care at home, compared with 36 percent of African Americans and 31 percent of whites (Figure 22). As a result, many

adults are not confident that they can manage their health conditions. Among Hispanics with chronic conditions, only 57 percent said they are very confident, while 62 percent of Asian Americans, 63 percent of African Americans, and 72 percent of whites reported being very confident ([Table 3](#)).

Adults who have a medical home reported better management of their chronic conditions, beginning with receipt of self-management plans. Less than one of four adults (23%) with chronic conditions in medical homes reported they did not receive a plan to manage their condition. In contrast, 35 percent of adults with a regular provider that is not a medical home did not receive such a plan, while 65 percent of adults without a regular provider did not receive such a plan (Figure 23).

Counseling on diet and exercise is critically important for adults with many chronic conditions, including hypertension and diabetes. Adults with these conditions are often overweight or obese, which contributes to the severity of their conditions. Overweight or obese adults who have a regular source of care are more likely to receive counseling on diet and exercise than those with no regular source of care. What’s more, providers counsel the uninsured at similar rates as they counsel the insured, although there are some persistent differences. Among adults with a medical home, 80 percent of the insured receive counseling, compared with 65 percent of the uninsured. Among adults with a regular provider that is not a medical home, 73 percent of the insured are counseled, versus 69 percent of the uninsured (Figure 24).

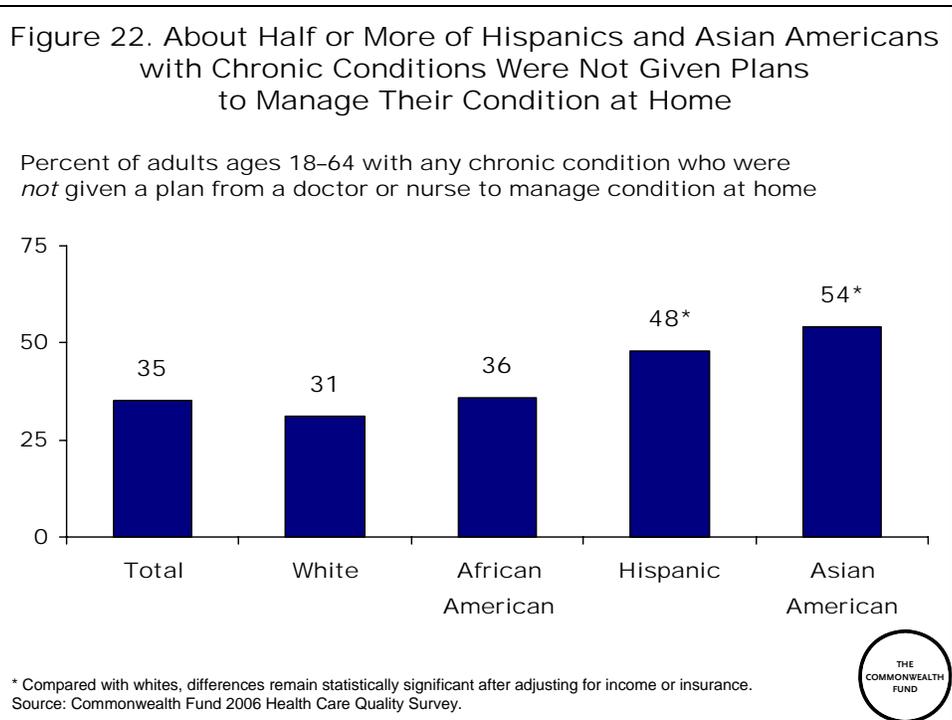
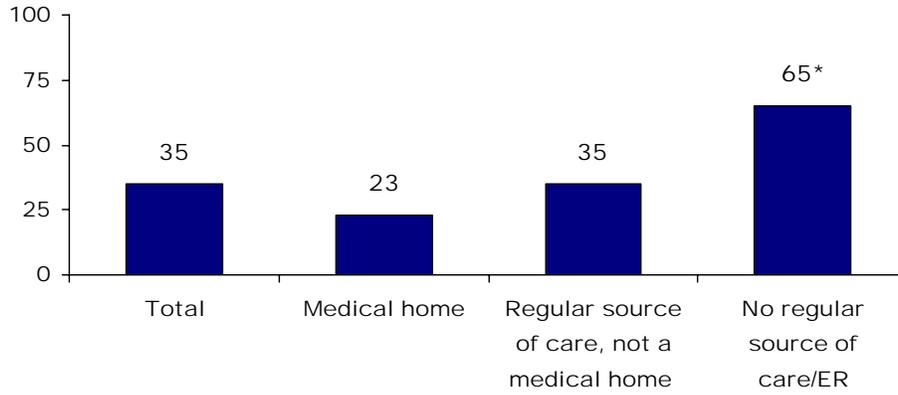


Figure 23. Less than One-Quarter of Adults with Medical Homes Did Not Receive Plans to Manage Their Conditions at Home

Percent of adults ages 18–64 with any chronic condition who were *not* given a plan from a doctor or nurse to manage condition at home

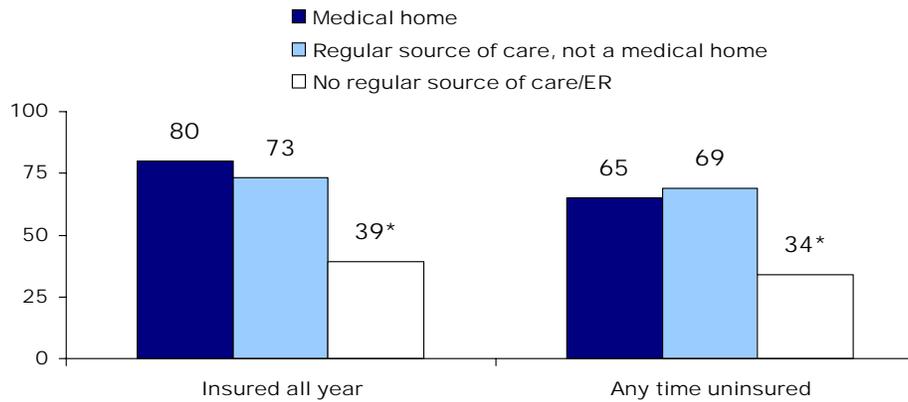


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
 * Compared with medical home, differences remain statistically significant after adjusting for income or insurance.
 Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure 24. Adults with a Medical Home Have Higher Rates of Counseling on Diet and Exercise Even When Uninsured

Percent of obese or overweight adults 18–64 who were counseled on diet and exercise by doctor

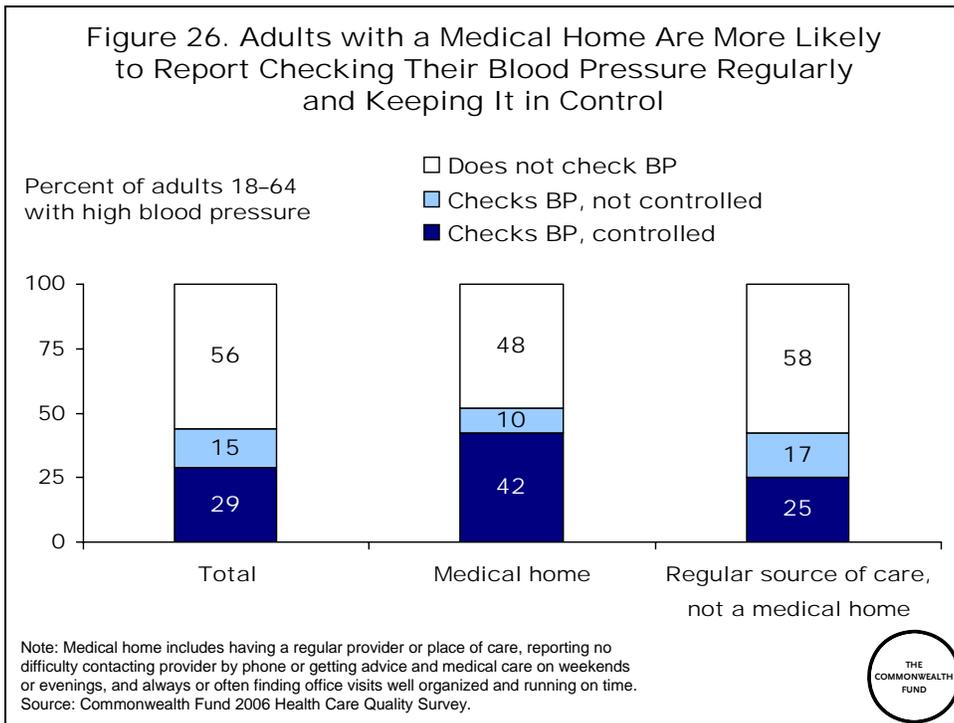
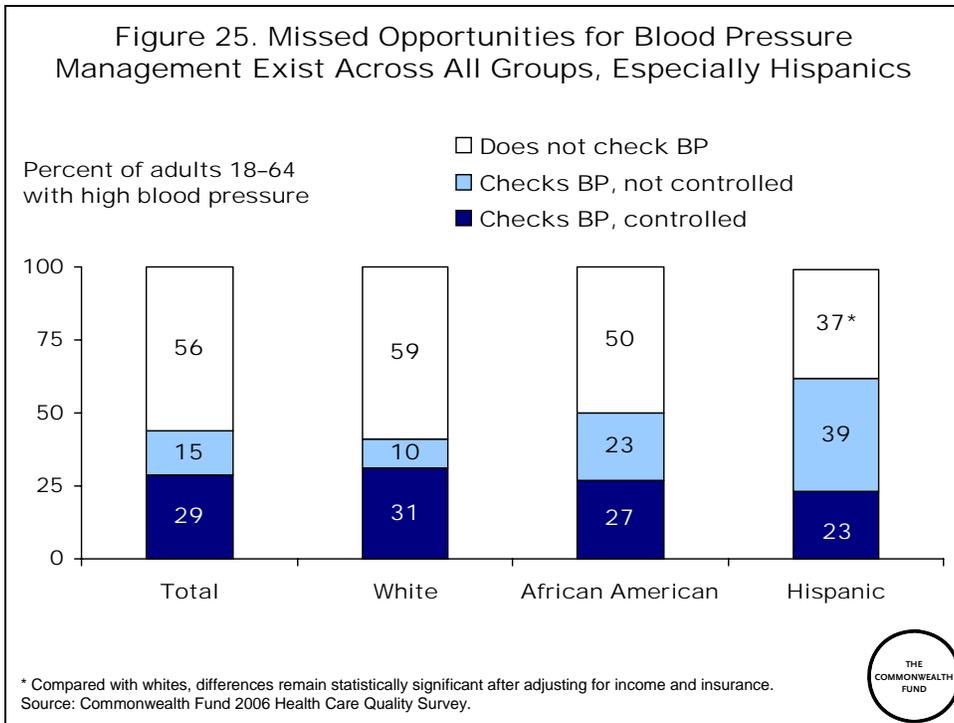


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
 * Compared with medical home, differences are statistically significant.
 Source: Commonwealth Fund 2006 Health Care Quality Survey.



Adults in medical homes are more likely to have their conditions well managed and well controlled. High blood pressure is the most common chronic condition among adults. It is a good example of a condition that requires patients to monitor themselves and make lifestyle changes, including changes to their diet and exercise. Survey results indicate that high blood pressure is generally poorly managed and controlled among all adults, but especially among Hispanics. As a first step in self-management, patients should monitor their blood pressure on a regular basis. The survey finds that over half of hypertensive adults do not do so regularly, with 59 percent of whites, 50 percent of African Americans, and 37 percent of Hispanics reporting they do not regularly check their blood pressure (Figure 25). Forty-four percent check regularly—but less than one of three adults with high blood pressure has it in control (defined as a systolic pressure <140 mm Hg and a diastolic pressure <90 mm Hg). Only 23 percent of Hispanics reported that their blood pressure is in control, compared with 27 percent of African Americans and 31 percent of whites.

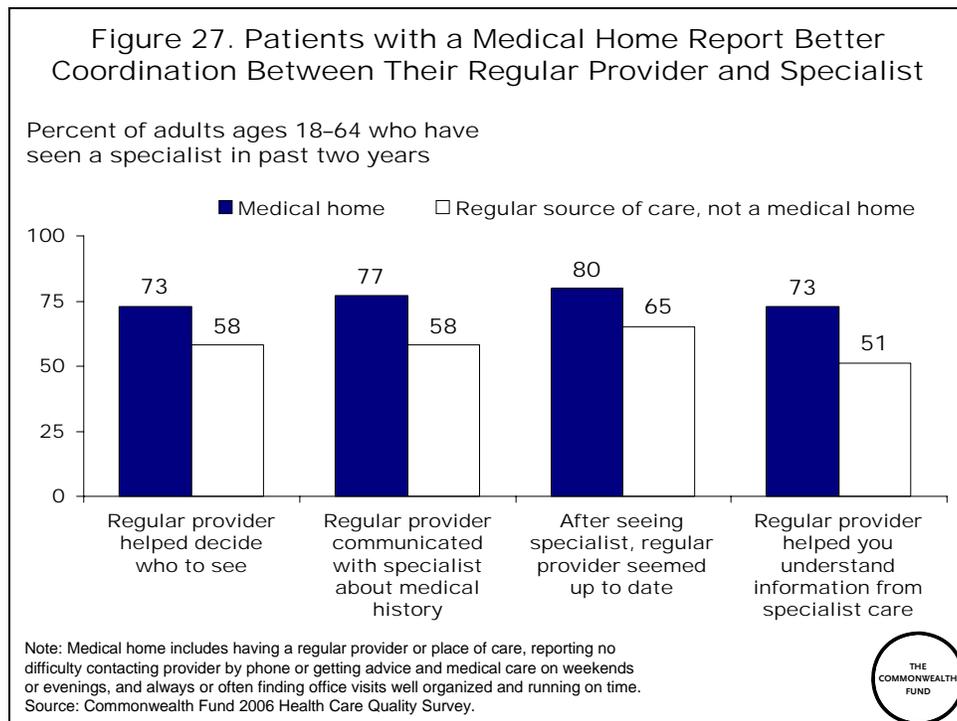
The survey also indicates that the best clinical results for hypertension are achieved among those with medical homes. More than half of hypertensive adults with a medical home reported checking their blood pressure on a regular basis, compared with 42 percent of hypertensive adults with a regular provider but not a medical home. Furthermore, hypertensive adults with a medical home are substantially more likely to have their blood pressure under control: 42 of hypertensive adults with a medical home reported they check their blood pressure regularly and it is in control, compared with only 25 percent of those with a regular provider but not a medical home (Figure 26). Overall, the survey finds significant room for improvement in management of chronic conditions among all adults. However, the results demonstrate that those who have medical homes have the best opportunities to manage their chronic conditions and achieve optimal outcomes.



Patients with medical homes have better coordination of care with specialists. In a medical home, care should be effectively coordinated across different domains of the health care system and between providers.¹⁰ Continuity and coordination

of care can reduce duplicative services and improve care for all patients, particularly those who have several different medical conditions or require care from multiple providers.

The survey asked respondents whether they had seen a specialist and whether their regular provider helped them coordinate specialty care. Specifically, respondents were asked whether their providers: 1) helped them decide which specialist to see, 2) communicated with the specialist about their medical history, 3) seemed up-to-date about the results from the specialist, and 4) helped them understand the information or care they received from the specialist. There were no racial differences on any of these measures of care coordination (Table 3). Yet, adults with medical homes—no matter their race—reported greater care coordination than those with a regular provider but no medical home. Three-fourths or more of adults with a medical home reported that their providers helped them decide which specialist to see, communicated with the specialist about their medical history, seemed up-to-date about the results from the specialist, and helped them understand the information or care they received from the specialist. Among adults with a regular provider but not a medical home, coordination between provider and specialists was not as strong (Figure 27).



SAFETY NET PROVIDERS

Community health centers and other public clinics play an important role in providing care for uninsured and low-income populations. Safety net institutions, such as public hospitals and community health centers, play a critical role in ensuring access to care, since they accept all patients regardless of their ability to pay. The survey found that community health centers and other public clinics provide care to 20 percent of the 46.8 million uninsured U.S. adults identified by the Commonwealth Fund survey. In addition, community health centers and other public clinics care for 20 percent of low-income adults who have health insurance (Figure 28). Physicians in private practice are the main source of care for both uninsured and low-income insured populations. Yet, a larger proportion of minority than white adults name community health centers or public clinics as their regular source of care. More than one of five Hispanics and 13 percent of African Americans use community health centers or public clinics as their regular place of care, compared with only 9 percent of whites and 7 percent of Asian Americans (Figure 29).

Although community health centers and other public clinics play an important role in providing health care to vulnerable patient populations, they are less likely than private doctors' offices to provide medical homes, as defined by the four indicators in the survey. Results show that 21 percent of adults who visit community health centers or public clinics as their usual source of care reported that their source of care provides all four indicators of a medical home, compared with 32 percent of adults who rely on private doctors' offices. For example, adults who use community health centers or public clinics were less likely than those who use private physician practices to report no difficulty contacting their provider by phone, but there are no such differences between community health centers or public clinics and other sources of care, including hospital outpatient departments (Figure 30). The survey also found that the systems for improving the quality of care provided in community health centers and other public clinics can be improved. For example, preventive care reminders and cholesterol screening are more common in doctors' offices than in community health centers or public clinics (Figure 31).

Figure 28. Community Health Centers Serve Large Numbers of Uninsured Adults and Insured Adults with Low Incomes

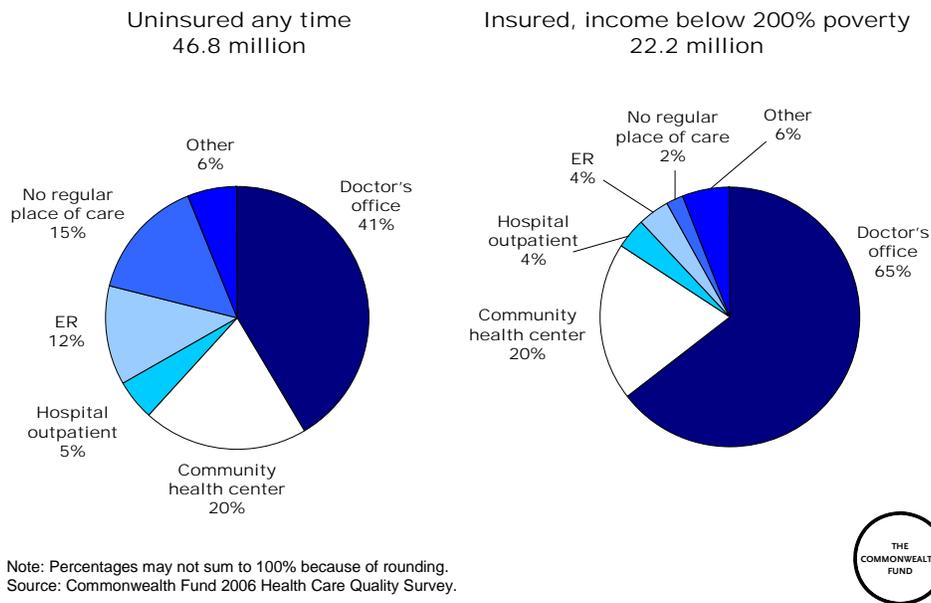
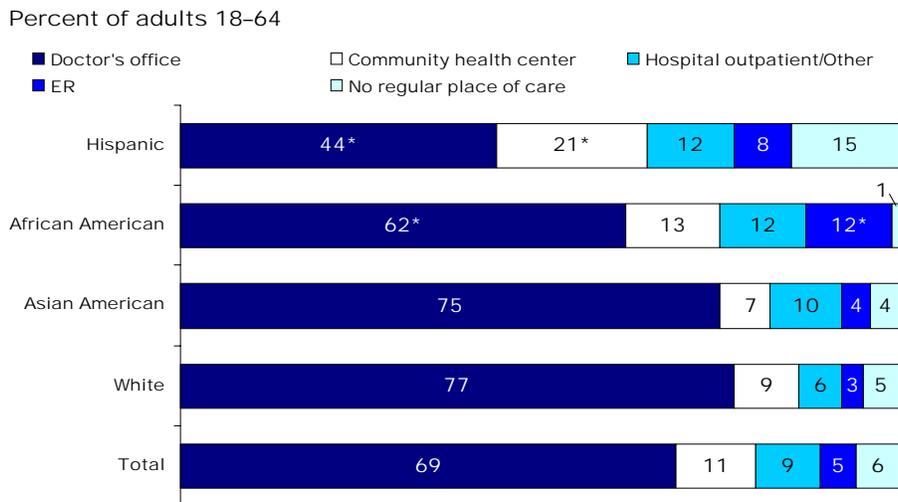


Figure 29. Hispanics and African Americans Are More Likely to Rely on Community Health Centers as Their Regular Place of Care



* Compared with whites, differences remain statistically significant after adjusting for insurance or income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

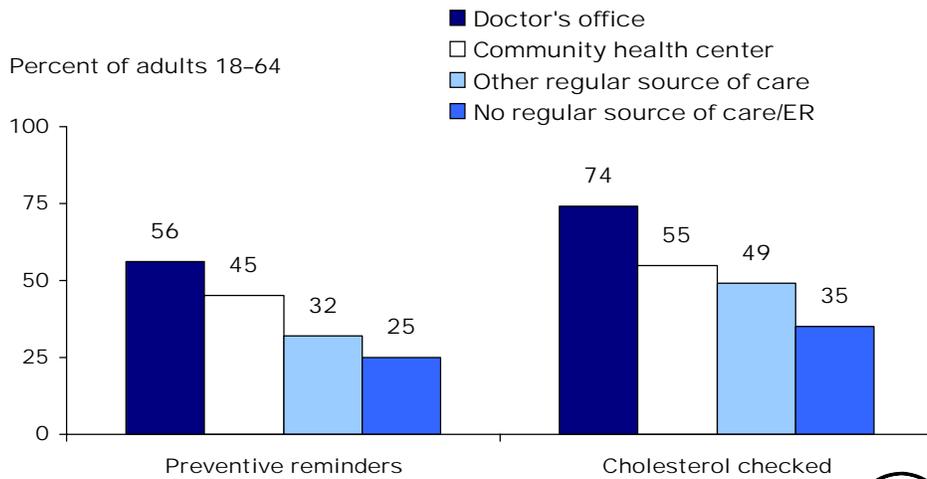
Figure 30. Indicators of a Medical Home
by Usual Health Care Setting
(adults 18-64)

| Indicator | Total | Usual Health Care Setting | | |
|---|-------|---------------------------|--|-----------------|
| | | Doctors' office | Community health center or public clinic | Other settings* |
| Regular doctor or source of care | 80% | 95% | 78% | 63% |
| <i>Among those with a regular doctor or source of care . . .</i> | | | | |
| Not difficult to contact provider over telephone | 85 | 87 | 77 | 77 |
| Not difficult to get care or medical advice after hours | 65 | 67 | 54 | 69 |
| Always or often find visits to doctors' office well organized and running on time | 66 | 68 | 56 | 60 |
| All four indicators of a medical home | 27 | 32 | 21 | 22 |

* Includes hospital outpatient departments and other settings.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



Figure 31. Preventive Care Reminders and Cholesterol Screening Are More Common in Doctors' Offices, But Community Health Centers Are Not Far Behind



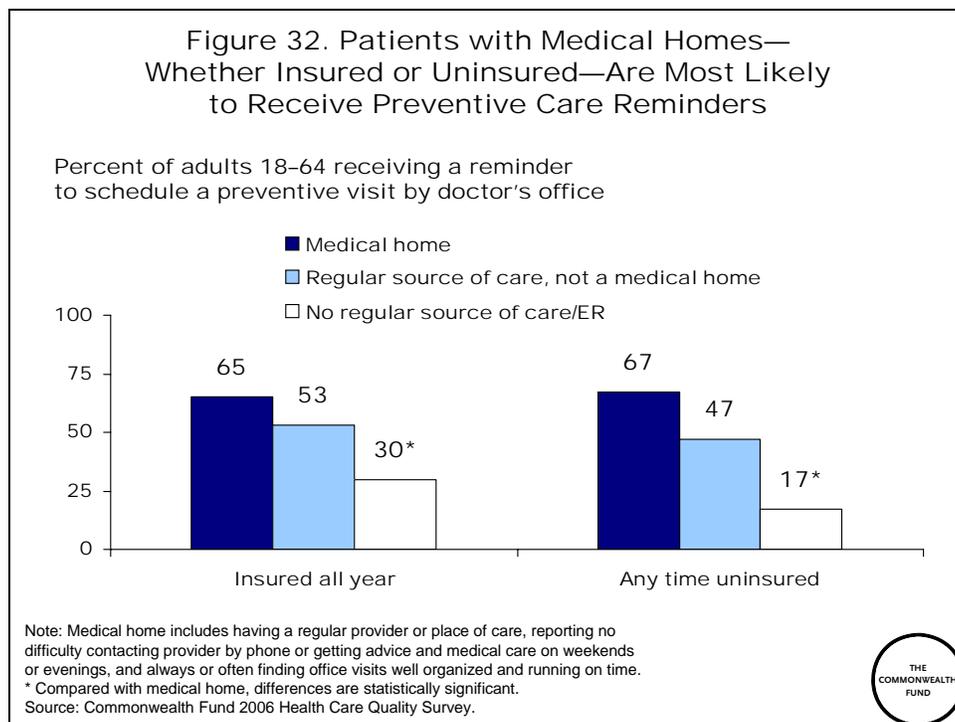
Source: Commonwealth Fund 2006 Health Care Quality Survey.

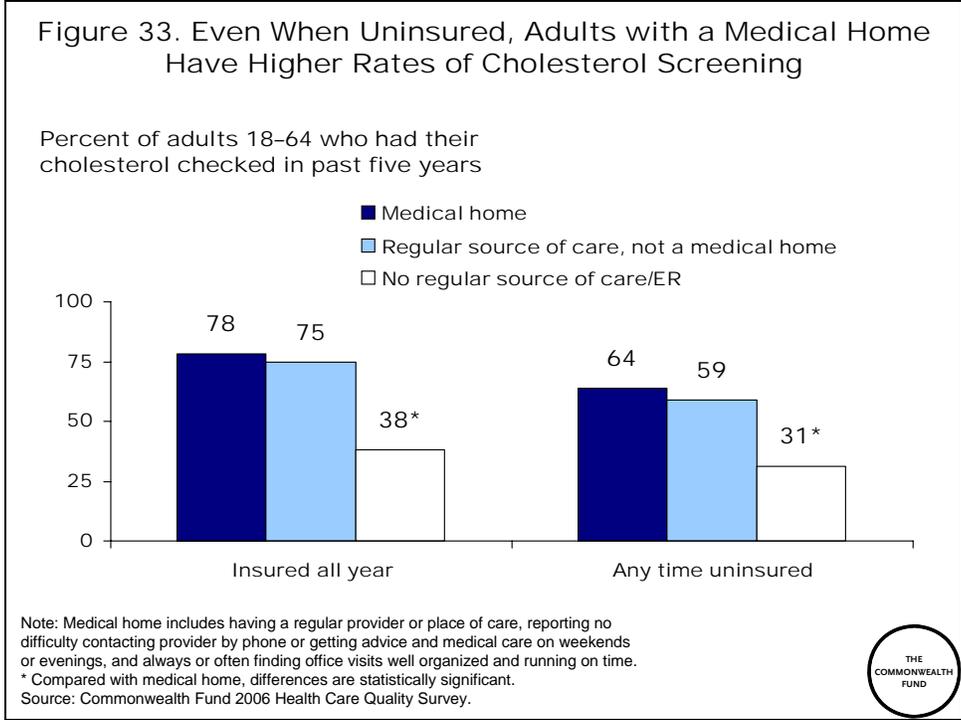


Access to a medical home improves quality and reduces disparities for the uninsured. Safety net providers that function as medical homes not only ensure access to needed care but also provide high-quality care. Compared with insured adults at all income levels, the uninsured are less likely to have a medical home (Figure 9). Yet, for uninsured patients that have access to a medical home through a high-quality safety net provider, disparities in some aspects of care can be ameliorated or even eliminated.

For example, having a medical home eliminates disparities in terms of the receipt of preventive care reminders between the insured and uninsured. Two-thirds of both insured and uninsured adults in medical homes receive reminders, compared with half of adults, both insured and uninsured, with regular providers that are not medical homes (Figure 32).

Regarding cholesterol screening, the rates are higher among insured adults with medical homes than those without such homes. Similarly, screening rates are higher among uninsured adults with medical homes than those without medical homes. However, disparities by insurance status are not eliminated. Among those with a medical home, 78 percent of insured adults receive cholesterol screening, compared with 64 percent of the uninsured (Figure 33).





CONCLUSIONS

Racial and ethnic disparities in health care have been documented for years. Evidence suggests that such disparities are not immutable, but instead can be addressed through targeted policies and practices. The Commonwealth Fund 2006 Health Care Quality Survey found that, when adults have insurance coverage and a medical home, racial and ethnic disparities in access and quality are reduced or eliminated.

Other studies have shown that access to primary care can reduce disparities.¹¹ But beyond basic primary care, this survey found that access to high-performing primary care *delivered in a medical home* may improve outcomes for vulnerable patient populations. Indeed, the vast majority of adults with a medical home reported that they always get the care they need, when they need it. Moreover, racial and ethnic differences in getting needed care disappear among those who have a medical home, while differences in preventive care and management of chronic conditions are either reduced or eliminated among those with a medical home.

The use of patient reminders also improves the quality of care of vulnerable patients. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders.

Overall, when health care settings provide medical homes, the disparities and poor outcomes experienced by minority, low-income, or uninsured adults can be reduced or eliminated. However, community health centers and other public clinics—which care for a significant proportion of uninsured and low-income adults—are less likely than private doctors’ offices to provide medical homes. Policies that specifically promote access to a medical home for vulnerable patient populations could help reduce or even eliminate health care disparities experienced by minority, low-income, or uninsured adults. Such policies include:

- ensuring stable health insurance coverage for all;
- publicly reporting which providers meet the standards of a medical home;
- recognizing and rewarding high-performing medical homes;
- working with physicians, community health centers and other public clinics, hospital outpatient departments, and other primary care providers to promote features of a medical home, including access to a regular provider, after-hours care, and coordination of health care services;
- working with primary care providers to promote use of preventive care reminders, encourage chronic disease self-management plans, and encourage counseling on diet and exercise; and
- campaigning to transform all primary care providers, including safety net providers, into medical homes.

Few providers or health care systems can say with certainty that there are no disparities in the quality of care delivered to their patients. However, the medical home holds extraordinary promise as a model for delivering high-quality care and eliminating disparities experienced by racial and ethnic minorities and uninsured patients. Replication of this model, particularly among safety net providers, could potentially improve the quality of care delivered to all patients while reducing disparities in care experienced by vulnerable patient populations.

NOTES

¹ N. Lurie and T. Dubowitz, “Health Disparities and Access to Health,” *Journal of the American Medical Association*, Mar. 14, 2007 297(10):1118–21.

² M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006); M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, Apr. 2004).

³ Doty and Holmgren, *Health Care Disconnect*, 2006.

⁴ M. Regenstein, J. Huang, L. Cummings et al., *Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems* (New York: The Commonwealth Fund, June 2005); L. S. Hicks, J. Z. Ayanian, E. J. Orav et al., “Is Hospital Service Associated with Racial and Ethnic Disparities in Experiences with Hospital Care?” *American Journal of Medicine*, May 2005 118(5):529–35.

⁵ American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee, “The Medical Home,” *Pediatrics*, July 2002 110(1 Pt. 1):184–86.

⁶ S. C. Schoenbaum and M. K. Abrams, *No Place Like Home* (New York: The Commonwealth Fund, Dec. 2006).

⁷ In February 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association developed principles to describe the characteristics of a patient-centered medical home. American Academy of Family Physicians et al., “Joint Principles of the Patient-Centered Medical Home” (Feb. 2007). Available at http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf.

⁸ Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academies Press, May 2002).

⁹ J. H. Wasson, D. J. Johnson, R. Benjamin et al., “Patients Report Positive Impacts of Collaborative Care,” *Journal of Ambulatory Care Management*, July–Sept. 2006 29(3 Special Issue).

¹⁰ American Academy of Family Physicians et al., “Joint Principles,” 2007.

¹¹ L. Shi, B. Starfield, R. Politzer et al., “Primary Care, Self-Rated Health, and Reductions in Social Disparities in Health,” *Health Services Research*, June 2002 37(3):529–50.

APPENDIX A. DATA TABLES

Table 1. Access to a Medical Home by Race/Ethnicity & Insurance and Poverty Status
 Base: Adults 18-64

| | Race/Ethnicity | | | | | Insurance and Poverty Status* | | | |
|---|----------------|-------|------------------|----------|----------------|-------------------------------|---------------------------|---------------------------|--------------------|
| | Total | White | African American | Hispanic | Asian American | Insured all year | Income above 200% poverty | Income below 200% poverty | Any time uninsured |
| Unweighted N | 2837 | 650 | 757 | 892 | 455 | | 1314 | 422 | 817 |
| Estimated number of adults (in thousands) | 177.3 | 114.6 | 20.2 | 24.9 | 8.3 | | 89.5 | 22.2 | 46.8 |
| Weighted percentages | 100% | 65% | 11% | 14% | 5% | | 50% | 13% | 26% |
| Usual place of care | | | | | | | | | |
| Doctor's office or private clinic | 69 | 77 | 62 | 44 | 75 | 85 | 65 | 20 | 41 |
| Community health center or public clinic | 11 | 9 | 13 | 21 | 7 | 6 | 20 | 4 | 12 |
| ER | 5 | 3 | 12 | 8 | 4 | 2 | 4 | 2 | 15 |
| No regular place of care | 6 | 5 | 1 | 15 | 4 | 1 | 4 | 4 | 5 |
| Hospital outpatient | 4 | 2 | 9 | 5 | 7 | 3 | 6 | 6 | 6 |
| Other/Don't know/Refused | 5 | 5 | 3 | 7 | 3 | 3 | 82 | 45 | 45 |
| Has regular doctor | 73 | 79 | 72 | 49 | 77 | 85 | 12 | | |
| No regular source of care (includes ER, no regular place of care, and no regular provider) | 20 | 15 | 21 | 43 | 16 | 9 | | | |
| Availability of regular provider by phone, and after hours | | | | | | | | | |
| Ability to contact your provider over the telephone about a health problem | | | | | | | | | |
| Very difficult | 6 | 6 | 7 | 9 | 4 | 4 | 12 | 10 | 9 |
| Somewhat difficult | 9 | 7 | 12 | 15 | 12 | 8 | 11 | 75 | 76 |
| Not too/Not at all difficult | 81 | 83 | 80 | 70 | 80 | 83 | | | |
| Ability to get care or the medical advice you need in the evenings or weekends | | | | | | | | | |
| Very difficult | 16 | 15 | 17 | 20 | 17 | 12 | 21 | 26 | 17 |
| Somewhat difficult | 18 | 19 | 15 | 19 | 17 | 20 | 20 | 17 | 17 |
| Not too/Not at all difficult | 47 | 45 | 57 | 42 | 48 | 47 | 51 | 44 | 44 |
| Don't know/Refused | 19 | 21 | 11 | 19 | 18 | 21 | 9 | 13 | 13 |
| <i>Very or somewhat difficult to do either of the above</i> | 39 | 38 | 36 | 47 | 38 | 36 | 45 | 49 | 49 |

| | Race/Ethnicity | | | | | Insurance and Poverty Status* | | |
|--|----------------|-------|------------------|----------|----------------|-------------------------------|---------------------------|--------------------|
| | Total | White | African American | Hispanic | Asian American | Insured all year | | Any time uninsured |
| | | | | | | Income above 200% poverty | Income below 200% poverty | |
| Rating of office visits | | | | | | | | |
| How often do you find the visits well organized and running on time? | | | | | | | | |
| Always | 31 | 30 | 34 | 34 | 30 | 29 | 39 | 31 |
| Often | 34 | 38 | 30 | 25 | 31 | 38 | 25 | 30 |
| Sometimes | 20 | 18 | 23 | 26 | 25 | 20 | 22 | 21 |
| Rarely or never | 13 | 13 | 12 | 13 | 11 | 12 | 14 | 16 |
| Indicators of medical home^a | | | | | | | | |
| Medical home | 27 | 28 | 34 | 15 | 26 | 30 | 34 | 16 |
| Regular source of care, not a medical home | 54 | 58 | 45 | 42 | 59 | 61 | 54 | 39 |
| No regular source of care/ER | 20 | 15 | 21 | 43 | 16 | 9 | 12 | 45 |
| Communication by email | | | | | | | | |
| Emails doctor now | 22 | 21 | 31 | 21 | 17 | 24 | 19 | 21 |
| Does not email doctor, but would like to | 16 | 15 | 13 | 23 | 23 | 17 | 17 | 18 |
| Does not email and does not want to | 24 | 22 | 26 | 27 | 31 | 22 | 23 | 28 |
| No access to computer | 10 | 10 | 13 | 12 | 6 | 5 | 25 | 13 |
| Don't know/Refused | 28 | 32 | 16 | 18 | 23 | 32 | 15 | 20 |

* Note: Respondents in the unknown or "mixed" race category are not shown; respondents who are insured with unknown poverty status are not shown.

^a Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone, or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006Health Care Quality Survey.

Table 2. Access, Preventive Care, and Physician Counseling
by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status
Base: Adults 18-64

| | Race/Ethnicity | | | | Indicators of a Medical Home ^a | | Insurance and Poverty Status* | | | |
|---|----------------|------|------------------|-------------------|---|------------------------|-------------------------------|--------------------|---------------------------------|--------------------|
| | Total | | African American | Hispanic American | Asian American | Regular source of care | No regular source of care/ER | Insured all year | Income at or above 200% poverty | Any time uninsured |
| | White | | | | Medical home | Not a medical home | poverty | below 200% poverty | uninsured | |
| Unweighted N | 650 | 757 | 892 | 455 | 771 | 1440 | 626 | 1314 | 422 | 817 |
| Estimated number of adults (in thousands) | 114.6 | 20.2 | 25.0 | 8.3 | 47.3 | 94.9 | 35.1 | 89.5 | 22.2 | 46.8 |
| Weighted percentages | 65% | 11% | 14% | 5% | 27% | 54% | 20% | 50% | 13% | 26% |
| Timely access to care | | | | | | | | | | |
| When you think about your health care in general, how often do you receive the health care YOU need WHEN you need it? | | | | | | | | | | |
| Always | 55 | 57 | 46 | 48 | 74 | 52 | 38 | 61 | 61 | 36 |
| Often | 23 | 24 | 16 | 24 | 19 | 28 | 15 | 26 | 18 | 20 |
| Sometimes | 13 | 11 | 17 | 16 | 4 | 15 | 19 | 9 | 15 | 22 |
| Rarely or never | 7 | 6 | 14 | 8 | 1 | 5 | 22 | 3 | 6 | 17 |
| When in need of medical attention, how soon are you able to get an appointment? | | | | | | | | | | |
| Same day or next day | 63 | 66 | 55 | 54 | 76 | 62 | 43 | 67 | 61 | 53 |
| 2 to 3 days | 14 | 14 | 9 | 20 | 11 | 16 | 10 | 16 | 10 | 13 |
| 4 to 5 days | 4 | 4 | 5 | 3 | 3 | 4 | 3 | 4 | 3 | 6 |
| 6 days or longer (includes more than a week, never able to get an appointment, went to ER/JCC) | 17 | 14 | 26 | 18 | 8 | 15 | 38 | 12 | 24 | 25 |

| | Race/Ethnicity | | | | Indicators of a Medical Home ^a | | Insurance and Poverty Status* | | | | |
|---|----------------|-------|------------------|-------------------|---|------------------------|-------------------------------|--------------------|---------------------------------|---------------------------|--------------------|
| | Total | White | African American | Hispanic American | Asian American | Regular source of care | | Any time uninsured | | | |
| | | | | | | Medical home | Not a medical home | Insured all year | Income at or above 200% poverty | Income below 200% poverty | Any time uninsured |
| Preventive care | | | | | | | | | | | |
| Doctor's office reminded you to schedule preventive care | 49 | 53 | 49 | 39 | 37 | 65 | 52 | 22 | 55 | 58 | 36 |
| Cholesterol checked in past five years | 66 | 67 | 63 | 56 | 62 | 76 | 72 | 34 | 73 | 65 | 47 |
| Received mammogram in past two years (women ages 40–64) | 73 | 73 | 77 | 76 | 78 | 79 | 74 | 49 | 80 | 76 | 44 |
| Received blood test or rectal exam for prostate cancer in past two years (men ages 40–64) | 52 | 54 | 57 | 39 | 54 | 77 | 47 | 34 | 55 | 64 | 35 |
| Physician counseling in past two years | | | | | | | | | | | |
| Doctor discussed about the health risks of smoking and ways to quit (among smokers) | 72 | 74 | 73 | 52 | 62 | 84 | 82 | 42 | 77 | 87 | 59 |
| Doctor discussed exercise and having a healthy diet and weight concerns you may be affect your health | 60 | 61 | 65 | 54 | 57 | 70 | 66 | 31 | 65 | 67 | 46 |
| Doctor discussed any emotional concerns you may be affect your health | 26 | 27 | 26 | 25 | 16 | 28 | 28 | 18 | 24 | 43 | 26 |

* Note: Respondents in the unknown or "mixed" race category are not shown; respondents who are insured with unknown poverty status are not shown.

^a Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone, or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 3. Chronic Disease Management and Coordination of Care
by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status
Base: Adults 18-64

| | Race/Ethnicity | | | | | Indicators of a Medical Home ^a | | Insurance and Poverty Status* | | |
|--|----------------|------------|------------------|------------|----------------|---|--------------------|---------------------------------|---------------------------|--------------------|
| | Total | White | African American | Hispanic | Asian American | Regular source of care | | Insured all year | | |
| | | | | | | Medical home | Not a medical home | Income at or above 200% poverty | Income below 200% poverty | Any time uninsured |
| Adult with a chronic disease (Unweighted N=) | 934 | 246 | 348 | 211 | 100 | 297 | 512 | 437 | 185 | 221 |
| Chronic disease management | | | | | | | | | | |
| Was <u>not</u> given plan to manage condition at home | 35% | 31% | 36% | 48% | 54% | 23% | 35% | 27% | 30% | 56% |
| How confident are you that you can control or manage your health problems? | | | | | | | | | | |
| Very confident | 68 | 72 | 63 | 57 | 62 | 75 | 65 | 73 | 66 | 66 |
| Somewhat confident | 23 | 21 | 28 | 24 | 25 | 20 | 24 | 21 | 24 | 20 |
| Not too/Not at all confident | 5 | 3 | 7 | 15 | 10 | 2 | 6 | 3 | 8 | 8 |
| Adults with high blood pressure or heart disease (Unweighted N=) | 511 | 139 | 201 | 103 | 56 | 153 | 290 | 257 | 87 | 119 |
| Management of high blood pressure | | | | | | | | | | |
| Does not check blood pressure regularly | 56% | 59% | 50% | 37% | — | 48% | 58% | 51% | 56% | 65% |
| Checks blood pressure regularly, BP not in control** | 15 | 10 | 23 | 39 | — | 10 | 17 | 16 | 16 | 16 |
| Checks blood pressure regularly, BP is controlled | 29 | 31 | 27 | 23 | — | 42 | 25 | 33 | 28 | 19 |
| Was not given plan to manage condition at home | 34 | 30 | 34 | 54 | — | 24 | 33 | 27 | 37 | 50 |
| Not too/Not at all confident can control or manage health problem | 6 | 3 | 8 | 19 | — | 2 | 5 | 2 | 10 | 11 |

| | Race/Ethnicity | | | | | Indicators of a Medical Home ^a | | Insurance and Poverty Status* | | |
|--|----------------|------------|------------------|------------|----------------|---|------------------------------|---------------------------------|---------------------------|------------|
| | | | | | | Regular source of care | No regular source of care/ER | Insured all year | Any time uninsured | |
| | Total | White | African American | Hispanic | Asian American | Medical home | Not a medical home | Income at or above 200% poverty | Income below 200% poverty | |
| Adults who have seen specialist in last two years (Unweighted N=) | 1075 | 328 | 312 | 221 | 171 | 342 | 699 | 641 | 175 | 163 |
| Coordination of care between specialist and regular doctor | | | | | | | | | | |
| Regular provider helped decide who to see | 62% | 61% | 62% | 62% | 74% | 73% | 58% | 60% | 77% | 60% |
| Regular provider communicated with him/her about medical care or history | 63 | 62 | 69 | 65 | 54 | 77 | 58 | 60 | 82 | 62 |
| Saw a specialist and regular provider seemed informed and up-to-date | 70 | 68 | 72 | 73 | 69 | 80 | 65 | 66 | 87 | 70 |
| Regular provider helped you understand about care received from specialist | 57 | 54 | 62 | 65 | 55 | 73 | 51 | 54 | 73 | 59 |

* Note: Respondents in the unknown or "mixed" race category are not shown; respondents who are insured with unknown poverty status are not shown.

** Controlled blood pressure is diastolic under 90 and systolic is under 140.

^a Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone, or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 4. Health Status by Race/Ethnicity and Insurance Status
 Base: Adults 18-64

| | Race/Ethnicity | | | | | Insurance Status | |
|---|----------------|-------|------------------|----------|----------------|------------------|--------------------|
| | Total | White | African American | Hispanic | Asian American | Insured all year | Any time uninsured |
| Unweighted N | 2837 | 650 | 757 | 892 | 455 | 2020 | 817 |
| Estimated number of adults (in thousands) | 177.3 | 114.6 | 20.2 | 24.9 | 8.3 | 130.5 | 46.8 |
| Weighted percentages | — | 65% | 11% | 14% | 5% | 74% | 26% |
| Self-rated health status | | | | | | | |
| Excellent or very good | 55 | 62 | 44 | 31 | 52 | 59 | 43 |
| Good | 30 | 26 | 39 | 38 | 38 | 28 | 37 |
| Fair/Poor | 15 | 11 | 17 | 29 | 10 | 13 | 20 |
| Current health conditions | | | | | | | |
| Diabetes or sugar diabetes | 7 | 6 | 10 | 8 | 6 | 8 | 5 |
| High blood pressure | 21 | 21 | 29 | 15 | 14 | 22 | 16 |
| Asthma, bronchitis, emphysema, or other lung conditions | 13 | 14 | 16 | 10 | 6 | 12 | 17 |
| Heart disease, heart failure or heart attack | 5 | 6 | 6 | 4 | 3 | 6 | 3 |
| <i>At least one chronic condition</i> | 34 | 35 | 43 | 24 | 22 | 35 | 31 |
| Disability or handicap limits daily activities | 14 | 14 | 15 | 14 | 8 | 15 | 14 |
| <i>Any chronic or any disability</i> | 39 | 40 | 48 | 29 | 25 | 40 | 37 |
| Obesity and overweight | | | | | | | |
| Underweight or normal weight | 37 | 41 | 26 | 25 | 65 | 39 | 32 |
| Overweight | 31 | 32 | 32 | 28 | 24 | 33 | 25 |
| Obese | 24 | 22 | 37 | 21 | 5 | 22 | 30 |
| Don't know/Refused | 7 | 4 | 5 | 26 | 6 | 5 | 13 |

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 5. Sociodemographic Characteristics by Race/Ethnicity
Base: Adults 18–64

| | Total | White | African American | Hispanic | Asian American |
|---|--------------|--------------|-------------------------|-----------------|-----------------------|
| Unweighted N* | 2837 | 650 | 757 | 892 | 455 |
| Estimated number of adults (in thousands) | 177.3 | 114.6 | 20.2 | 24.9 | 8.3 |
| Weighted percentages | — | 65% | 11% | 14% | 5% |
| Age | | | | | |
| 18–29 | 24 | 22 | 28 | 33 | 27 |
| 30–49 | 48 | 44 | 48 | 51 | 54 |
| 50–64 | 28 | 33 | 24 | 16 | 19 |
| Education | | | | | |
| Less than high school | 13 | 7 | 15 | 41 | 6 |
| High school diploma or equivalent | 35 | 36 | 41 | 30 | 22 |
| Some college/Technical | 24 | 25 | 25 | 18 | 20 |
| College graduate or higher | 28 | 32 | 18 | 11 | 51 |
| Annual income | | | | | |
| Less than \$20,000 | 16 | 12 | 32 | 23 | 10 |
| \$20,000–\$39,999 | 19 | 17 | 24 | 25 | 15 |
| \$40,000–\$59,999 | 16 | 18 | 15 | 13 | 15 |
| \$60,000+ | 34 | 40 | 20 | 13 | 41 |
| Don't know/Refused | 15 | 13 | 9 | 25 | 18 |
| Poverty status | | | | | |
| Under 100% poverty | 10 | 6 | 23 | 18 | 9 |
| 100%–199% poverty | 14 | 13 | 19 | 20 | 9 |
| Under 200% poverty | 24 | 18 | 42 | 39 | 17 |
| 200% poverty or more | 61 | 69 | 49 | 36 | 64 |
| Don't know/Refused | 15 | 13 | 9 | 25 | 18 |
| Work status | | | | | |
| Full-time | 60 | 62 | 59 | 53 | 62 |
| Part-time | 11 | 11 | 9 | 14 | 14 |
| Not currently working | 28 | 26 | 31 | 32 | 24 |
| Family work status | | | | | |
| At least 1 full-time worker | 47 | 51 | 35 | 42 | 59 |
| Only part-time workers | 35 | 33 | 38 | 40 | 27 |
| No worker in family | 18 | 16 | 26 | 17 | 13 |
| Nativity status | | | | | |
| Born in U.S. | 83 | 96 | 92 | 38 | 24 |
| Foreign born, living in U.S. less than 5 years | 3 | 1 | 2 | 14 | 6 |
| Foreign born, living in U.S. less 5–10 years | 3 | 1 | 1 | 12 | 11 |
| Foreign born, living in U.S. more than 10 years | 11 | 3 | 4 | 35 | 58 |
| Type of insurance coverage at time of survey | | | | | |
| Employer | 63 | 68 | 54 | 43 | 71 |
| Individual/Other | 8 | 10 | 6 | 6 | 12 |
| Public (Medicaid/Medicare) | 12 | 9 | 23 | 16 | 7 |
| Uninsured | 17 | 13 | 17 | 35 | 10 |

| | Total | White | African American | Hispanic | Asian American |
|---|-------|-------|------------------|----------|----------------|
| Stability of insurance throughout year | | | | | |
| Insured all year | 74 | 79 | 72 | 51 | 81 |
| Insured now, time uninsured in past year | 9 | 8 | 11 | 14 | 8 |
| Uninsured now | 17 | 13 | 17 | 35 | 10 |
| <i>Any time uninsured in past year</i> | 26 | 21 | 28 | 49 | 18 |
| Insurance and poverty status | | | | | |
| Below 200% of poverty | | | | | |
| Insured all year | 51 | 55 | 54 | 42 | 54 |
| Uninsured now, time uninsured in past year | 17 | 14 | 18 | 19 | 18 |
| Uninsured now | 32 | 31 | 28 | 39 | 28 |
| At or above 200% of poverty | | | | | |
| Insured all year | 83 | 84 | 85 | 69 | 90 |
| Uninsured now, time uninsured in past year | 6 | 6 | 6 | 12 | 5 |
| Uninsured now | 11 | 10 | 9 | 20 | 5 |

* Note: Other and "mixed" race/ethnicity category not shown.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

APPENDIX B. SURVEY METHODOLOGY

The Commonwealth Fund 2006 Health Care Quality Survey was conducted by Princeton Survey Research Associates International from May 30 through October 19, 2006. The survey consisted of 25-minute telephone interviews, conducted in either English or Spanish, among a random, nationally representative sample of 3,535 adults age 18 and older living in the continental United States. This report restricts the analysis to the 2,837 respondents ages 18 to 64.

The sample was designed to target African American, Hispanic, and Asian American households. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 18 and older living in the continental United States. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, marital status, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 177.3 million adults ages 18 to 64.

This study groups respondents by four race/ethnic groups, including non-Hispanic white, non-Hispanic African American, Hispanic, and non-Hispanic Asian American. The study also classifies adults by insurance status and annual income. Adults reporting they were uninsured when surveyed or were uninsured during the past 12 months were classified as uninsured any time during the year. Adults who were insured all year were further classified into two groups by their poverty status: insured all year with income below 200 percent of the federal poverty level, or insured all year with income at or above 200 percent of poverty. Ten percent of adults ages 18 to 64 who were insured all year did not provide sufficient income data for classification.

The survey has an overall margin of sampling error of ± 2.9 percentage points at the 95 percent confidence level. The 50 percent response rate was calculated consistent with standards of the American Association for Public Opinion Research.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

[*Disparities in Health Care Are Driven by Where Minority Patients Seek Care*](#) (June 25, 2007). Romana Hasnain-Wynia, David W. Baker, David Nerenz, Joe Feinglass, Anne C. Beal, Beth Landrum, Raj Behal, and Joel S. Weissman. *Archives of Internal Medicine*, vol. 167, no. 12.

[*Improving the Management of Chronic Disease at Community Health Centers*](#) (March 1, 2007). Bruce E. Landon, LeRoi S. Hicks, A. James O'Malley, Tracy A. Lieu, Thomas Keegan, Barbara J. McNeil, and Edward Guadagnoli. *New England Journal of Medicine*, vol. 356, no. 9.

[*Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care*](#) (January 2007). Bruce Siegel, Marsha Regenstein, and Karen Jones.

[*No Place Like Home*](#) (December 2006). Stephen C. Schoenbaum and Melinda K. Abrams.

[*Patients Report Positive Impacts of Collaborative Care*](#) (July–September 2006). John H. Wasson, Deborah J. Johnson, Regina Benjamin, Jill Phillips, and Todd A. MacKenzie. *Journal of Ambulatory Care Management*, vol. 29, no. 3.

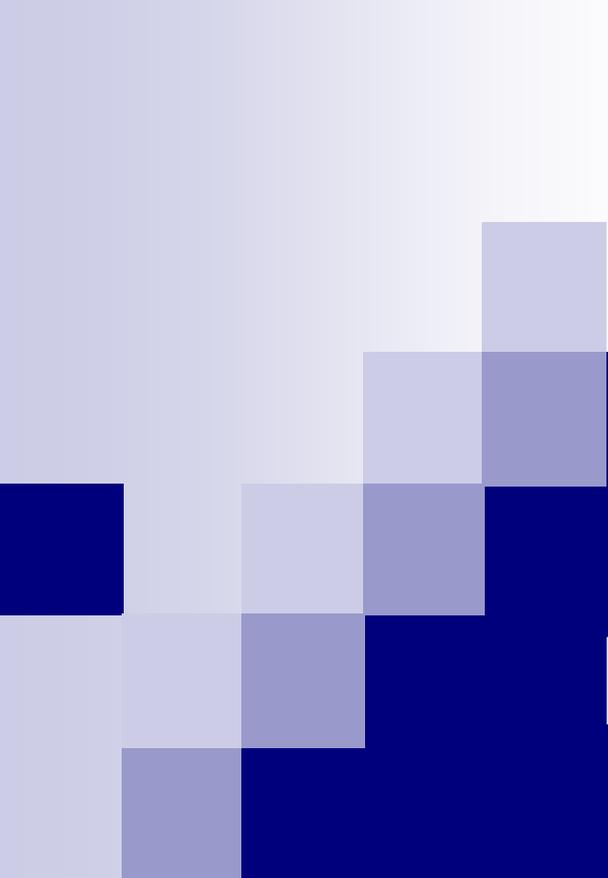
[*Health Care Disconnect: Gaps in Coverage and Care for Minority Adults*](#) (August 2006). Michelle M. Doty and Alyssa L. Holmgren.

[*Comparative Perspectives on Health Disparities*](#) (February 2006). Vanessa Northington Gamble, Deborah Stone, Kala Ladenheim, Brian K. Gibbs et al. *Journal of Health Politics, Policy and Law*, vol. 31, no. 1.

[*Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems*](#) (June 2005). Marsha Regenstein, Jennifer Huang, Linda Cummings, Daniel Lessler, Brendan Reilly, and Dean Schillinger.

[*Is Hospital Service Associated with Racial and Ethnic Disparities in Experiences with Hospital Care?*](#) (May 2005). LeRoi S. Hicks, John Z. Ayanian, E. John Orav, Jane Soukup, Michael McWilliams, Sharon S. Choi, and Paula A. Johnson. *American Journal of Medicine*, vol. 118, no. 5.

[*Unequal Access: Insurance Instability Among Low-Income Workers and Minorities*](#) (April 2004). Michelle M. Doty and Alyssa L. Holmgren.



The Medical Home Model of Primary Care

Presentation to the Oregon Health Fund Board and
Delivery System Committee

Jeanene Smith MD, MPH

December 12, 2007



SB 329: The Healthy Oregon Act

- Calls for greater emphasis on primary and preventative care, chronic disease management, health promotion and wellness
- Calls for payment reform that rewards more efficient and effective care
- Specifically states that all participants in the Oregon Health Fund Program should have a “primary care medical home”



Challenges Facing Primary Care System in Oregon

- Workforce shortage
- Decreasing access to providers
- Overwhelming workload for primary care providers
- Patients not receiving recommended primary care
- Inadequate and inequitable reimbursement

So what is a “Medical Home”?

- “Right care at the right place at the right time”
(Institute for Medicine)
- “The cornerstone of our entire system is the support of long-term, trusting, continual ***relationships*** with our customers”
(D. Eby- Southcentral Foundation – Alaska)

And also includes: Integration of medical care with the community’s behavioral, dental and public health resources as well as social services to maximize health

Patient-Centered Medical Home

– One definition

- Whole Person Orientation
- Coordinated and/or Integrated Care
- Quality and Safety
- Enhanced Access
- Personal Physician
- Physician Directed Medical Practice
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home

Joint Principles released by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association in February 2007

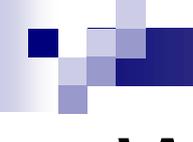


Evidence to Support Primary Care and Medical Home Model

- Countries with stronger primary care systems have better health outcomes and lower per-capita costs
- Having a regular source of preventive and primary care is associated with:
 - Lower per person costs
 - Fewer emergency room visits and hospitalizations
 - Better health outcomes
 - Higher patient satisfaction
- Medical homes have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities

Medical Home Initiatives and Demonstration Projects

- PEBB requires vendors providing benefits to state employees to work towards providing medical home services to enrollees
 - Kaiser, Regence, Samaritan, Providence
- North Carolina Community Care created networks of providers to link Medicaid population with primary care homes
 - Resulted in better health outcomes and lower costs
- Many others listed in background paper – presenters will describe other efforts in OR



What are the necessary supports to make and sustain a change?

- “Fully integrated care means that every part of the system is intentionally planned to avoid duplication and maximize unique capabilities...this takes planning, learning and supporting the workforce through continual change”

(M. Tierney – Southcentral Foundation – Alaska)

Key Considerations

- The relationship at the center of this paradigm change is that of the patient and his/her primary care team
- Transforming Oregon's primary care practices into medical homes must be seen as one part of wider effort to revitalize primary care and overall delivery of healthcare
- Providers (including physicians, nurses, etc.) must be part of any successful transformation process
- The workforce will need ongoing support through the redesign process, including learning collaborations and quality improvement trainings



Key Considerations - continued

- No one “right” way – communities and practices must have flexibility to innovate and develop models that work in particular settings
- Special consideration must be given to how medical home concept can be implemented in rural communities and for vulnerable populations
- Payment reform needed to reward provision of patient-centered, high-quality, efficient care



Today's Presentations

- Health Plan Initiatives

- Dr. David Labby - CareOregon
- Dr. Ralph Prows - Regence Blue Cross Blue Shield
- Dr. Thomas Hickey - Kaiser Permanente

- Clinic/Provider Initiatives

- Dr. Chuck Kilo— GreenField Health, Better Health Initiative
- Dr. David Dorr – OHSU Care Management Plus

Joint Meeting of Oregon Health Fund Board and Delivery System Committee
December 12, 2007
Speaker Bios

David Dorr

David Dorr, MD, is assistant professor of medical informatics and clinical epidemiology at the Oregon Health & Science University School of Medicine. Dr. Dorr earned his BA in Economics and his MD from Washington University in St. Louis. He then completed an Internal Medicine residency at Oregon Health & Science University, and earned a Master's in Medical Informatics and Health Services Administration from the University of Utah. His current projects include Expanding Guidelines to Collaborative Care Management and he is the principal investigator for the Care Management Plus project. He also works with RADAR (research on Adverse Drug Events and Reports) and the Internal Review Board to improve patient safety. Additionally, his work on collaborative systems has led him to align with the Creating HealthVet Informatics Applications for Collaborative Care (CHIACC) Group.

Thomas Hickey

Thomas Hickey, MD, is clinical director of population care for the Kaiser Northwest region. He is a family physician and practices at the Kaiser Clinic in Longview, WA. Dr. Hickey earned his BS in Biology from the University of California-Irvine, his MS in Pharmacognosy and Pharmacology from the University of Illinois and his MD from Rush Medical School in Chicago. He is board certified by the American Board of Family Medicine.

Chuck Kilo

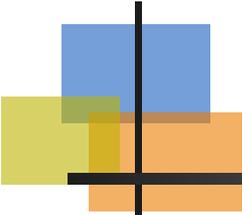
Chuck Kilo, MD, is the CEO of GreenField Health, a network of medical practices and a teaching and consulting company serving those interested in health care quality and performance improvement. He is executive director of the newly formed non-for-profit Trust for Healthcare Excellence which promotes the collective efforts and conditions necessary for health and healthcare excellence. He is a fellow and senior faculty of the Institute for Healthcare Improvement (IHI) where he was previously vice president. At IHI, he developed and led the international Idealized Design of Clinical Office Practices initiative. This work sparked a national focus on medical practice performance improvement. Dr. Kilo works regularly with IHI, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Board of Internal Medicine (ABIM), and others on issues pertinent to health care quality and performance improvement. He is on the Board of Directors of the Foundation for Medical Excellence, TransforMED (a subsidiary of the AAFP), the ACP's Center for Practice Innovation, and Kryptiq Corporation. Dr. Kilo speaks frequently on topics related to health care quality and safety, health system design, information technology, and performance improvement. He is a practicing internist with subspecialty training in infectious diseases. He attended Washington University School of Medicine where he also completed his internal medicine training. He subsequently completed an infectious diseases fellowship and Master of Public Health at Harvard University.

David Labby

David Labby, MD, PhD, is Medical Director of CareOregon, a Medicaid Health Plan serving 90,000 members under the Oregon Health Plan. He is a practicing general internist and Assistant Professor of Family Medicine at OHSU. He received his MD at Indiana State University and his PhD in Cultural Anthropology from the University of Chicago. Dr. Labby has been at CareOregon since 2000 and has focused on clinical quality and program development. He is the principal investigator for a grant from the Robert Wood Johnson Foundation (RWJF) on Depression in Primary Care and for a grant from the Center for Health Care Strategies on Making the Business Case for Quality focusing on case management of complex high-risk patients. He has also led programs on asthma and chronic pain management.

Ralph Prows

Ralph Prows, MD, is vice president and chief medical officer of Regence Blue Cross Blue Shield of Oregon. Dr. Prows joined Regence BCBSO in September 2004. He is responsible for the direction and coordination of health care services to all lines of business and products offered by Regence. He also directs the development and implementation of medical management activities for Oregon and has shared accountability for medical management functions in Washington, Idaho and Utah for The Regence Group. He also serves on the Board of Directors for the Oregon Health Care Quality Corporation and Oregon Health Policy Commission's Quality and Transparency Workgroup. Dr. Prows earned a medical degree from Tulane University School of Medicine and completed his residency in internal medicine at Oschner Foundation Hospital in New Orleans. He is board certified by the American Board of Internal Medicine and has current state medical licenses in Massachusetts and Oregon.



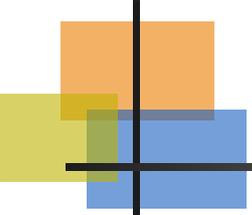
Primary Care Home: Overview of Collaboratives

Joint Meeting of the Oregon Health Fund Board,
Delivery System Committee and Oregon Health Policy
Commission

December 12, 2007

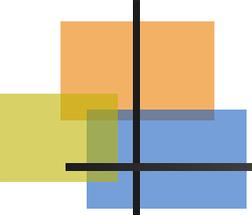
Ralph M. Prows, MD
Senior Medical Director
Regence BlueCross BlueShield of Oregon





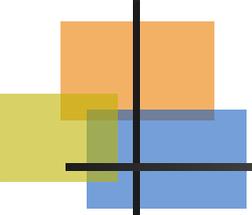
Agenda

- **The National Landscape** – What's going on at the BCBS Association Level?
- **The Regional Landscape** – What's going on at Regence?
- **The Future Directions** - research and development of the primary care home



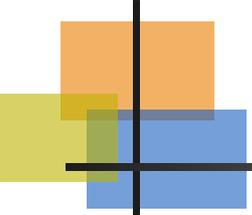
The National Landscape – What's going on at the BCBS Association Level?

- Patient-Centered Medical Home Collaborative
 - 22 BCBS Plan demonstrations
 - AAFP, ACP, AOA, and AAP
- Patient-Centered Primary Care Collaborative –
 - BCBSA = 1st payer on Executive Committee
 - NBGH, NBCH, GM, many others
 - AARP
 - Bridges to Excellence, NCQA, DMAA
 - AAFP, ACP, AOA, and AAP



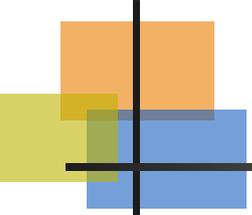
The Regional Landscape – What's going on at Regence?

- Why is Regence engaged in this?
- Pilots
 - Clinical Performance Improvement
 - Pay 4 Condition
 - Patient Satisfaction
 - HIT Community Connectivity
 - Expanded Primary Care Home Collaboratives



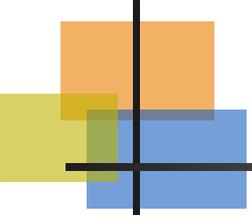
Clinical Performance Improvement Pilots

- Criteria for selection: develop infrastructure for Patient Centered Medical Home
 - EHR in place or staged for implementation
 - Intention to implement patient-centered chronic care model
 - Generally focused on diabetes, expand to other conditions
 - Build-out registries and redesign of delivery
 - Track outcomes over time



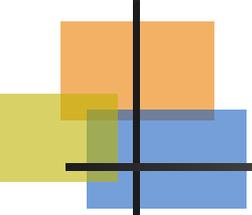
Clinical Performance Improvement Pilots

- 2006-2007: Legacy, Family Physicians Group, PeaceHealth, North Bend Medical Center, Corvallis Clinic
- 2007-2008: Portland Family Practice, Pacific Medical Group, High Lakes, Greenfield, PeaceHealth



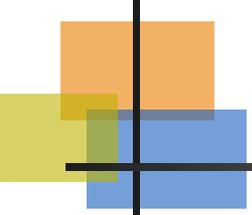
Pay 4 Condition

- OHSU
- Goal: model a risk-stratified reimbursement system tied to improving the care of patients with diabetes
- Team approach
- Population based



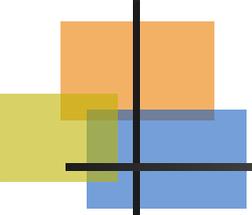
Patient Satisfaction

- **5 Medical groups**
 - Portland Clinic, Salem Clinic, Womens Healthcare Associates, Orthopedic and Fracture Care, Northwest Primary Care
- **MGMA survey**, standard methodology
- **Scientifically comparable reports**
 - physician-specific + group level reports compared to peers, region and nation
- **Data-directed improvement plans, expert redesign assistance**
- **Goal:** achieve 90th percentile of MGMA nationally



The Future Directions - research and development of the medical home

- Expanded Primary Care Home Collaboratives
 - 3 year pilots
 - 2 large scale collaboratives in Oregon, 1 in Washington
 - Demonstrated leadership and record of accomplishment in prior CPI pilots
 - Rigorous research design and evaluation strategy
- Process redesign, clinical quality, utilization and cost outcomes



Conclusions

- Primary care medical home: a compelling concept with promising early trends
- More research needed
 - Quality impact
 - Global cost impact
 - Reimbursement methodology

Oregon Health Fund Board

Kaiser Permanente Vision

Providing Members With a Medical Home

Total Panel Ownership



Why Should Patients Have a Medical Home?
Why Should You Advocate for Such a
Healthcare Delivery System?

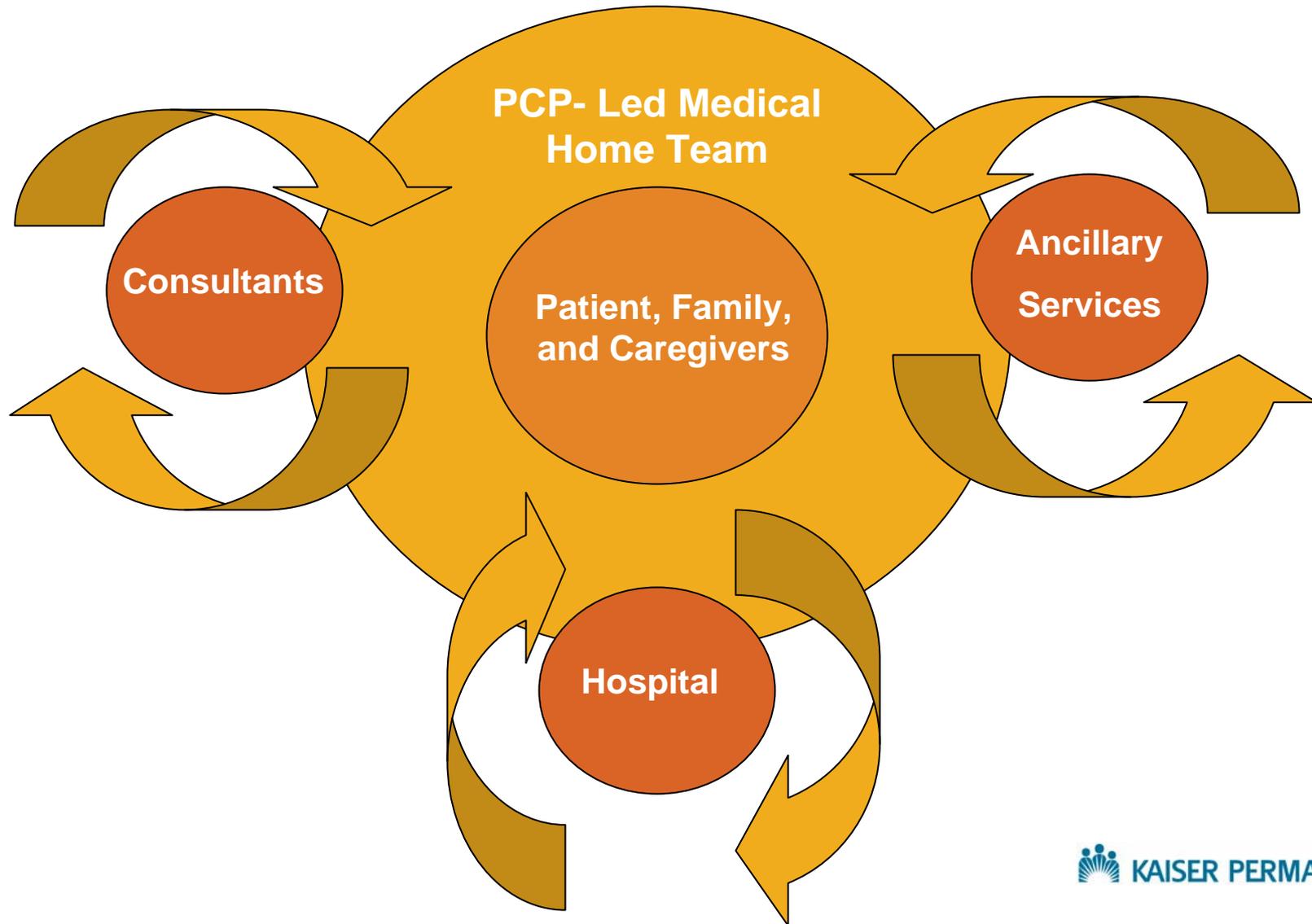


Service Improves - Members have a home that coordinates all their care

Quality Improves - Members with a primary care clinician/home have consistently better quality outcomes

Resource Stewardship Improves - States with more PCPs, and patients who have a PCP, experience more cost effective care

Primary Care Vision



Primary Care Vision



All members are attached to a primary care physician

Members have several choices to access their physician

- Office visits
- Scheduled phone encounters
- Email encounters

The Medical Home Challenges for Kaiser



Service Excellence is the Key

- Goals
 - Service Culture Improvement
 - Improved Phone Service for Members
 - Access Improvement Primary Care
 - Enhancing the ability of members to develop a relationship with a primary care clinician
 - Increasing appointment availability to better meet members needs
 - Access Improvement Specialty Care
 - Reduce time from referral to appointment
 - Direct access for selected specialties

Total Panel Ownership and Our Electronic Medical Record (EMR)



Our Electronic Medical Record facilitates the Medical Home Model. All care is documented in one EMR, accessible by all members of the care team.

The Panel Support Tool facilitates comprehensive Inreach

The Panel Support Tool facilitates focused Outreach from the team and centrally

Our EMR is the Member's EMR



The member can access much of their EMR via kp.org

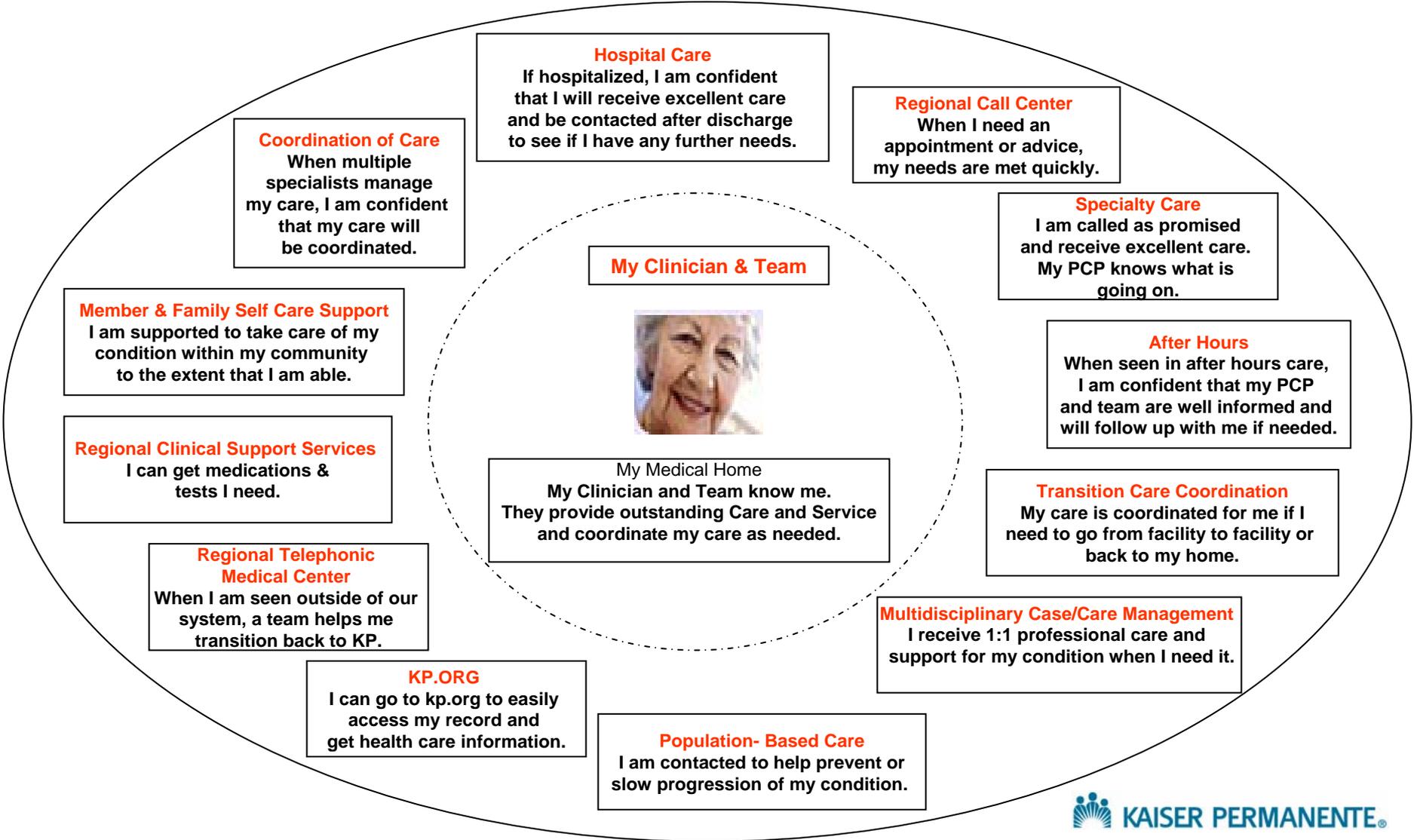
- Medical conditions, labs, vaccine records, appointments

Health Risk Assessment coming in 2008

- Available on kp.org to all members
- Integrated into our EMR
- Members receive suggestions regarding prevention issues and lifestyle changes to address

Member Perspective & KPNW Departments

KPNW Primary Care Model of Care for Quality & Service



Sources



- States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality. *Baicker K, Chandra A. Medicare spending, The Physician workforce and Beneficiaries' Quality of Care. Health affairs, 2004*
- International comparisons of health care systems have shown a relationship at the macro level between a well-structured primary health care plan and lower total health care costs...Provider continuity in family medicine remains one of the most important explaining variables of total health care costs (including costs for specialist visits and hospitalizations). *De Maeseneer JM, et al. Provider continuity in family medicine: Does it make a difference for total health care costs? Ann Fam Med 2003;1:144-148*
- 94% of patients value having a primary care physician who knows about all their medical problems. *Grumbach K, et. al.. Resolving the gatekeeper conundrum. JAMA 1999;282:261-266*
- When more primary care physicians, per person, are practicing in a community, hospitalization rates are lower. *Parchman ML, Culler S. Primary care physicians and avoidable hospitalization. J Fam Pract 1994;39:123-128.*
- Mortality rates are lower where there are more primary care physicians, but this is not the case for specialist supply. Increasing the supply of specialists will not improve the US position in population health relative to other industrialized countries, and is likely to lead to greater disparities in health status and outcomes. *Starfield B, Shi L, et. Al. The effects of specialist supply on populations' health: assessing the evidence. Health Aff (Millwood). 2005 Jan-Jun; Suppl Web Exclusives:W5-97-W5-1-7*
- Physician services: 25% of national health services spending. Primary Care: 6-8% of total spending for personal health services. *Goroll A, et. al. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. JGIM 2007;22:410-415*

Unintended Consequences of Resource-Based Relative Value Scale Reimbursement

John D. Goodson, MD

MEDICINE'S GENERALIST BASE IS DISAPPEARING AS a consequence of the reimbursement system crafted to save it—the resource-based relative value scale.¹ The US physician workforce is unique among developed economies of the world. Virtually all European countries have a broad generalist foundation comprising 70% to 80% of practicing physicians. The United States is the opposite. Starfield² has summarized the benefits of a generalist workforce as access to health service for relatively deprived populations; care equal to specialists in most situations (recognizing the invaluable contribution of the specialist physicians but acknowledging that the diffusion of knowledge increases the ability of the non-specialist to provide up-to-date care); improved preventive service delivery; efficient management of multiple simultaneous medical, surgical, and mental health problems in active and fully functional patients; provision of continuity in the health care experience, advice, and counsel where appropriate and access to appropriate diagnostic, consultative, and specialty services; and, in conjunction, reduced unnecessary specialty testing and consultation.

Over the last 4 decades, medical and surgical practice has transformed from a reactive profession to a proactive profession. Evidence from numerous clinical investigations in many different settings shows that patients with any of the 3 most common conditions—hypertension, diabetes, hypercholesterolemia—benefit from early treatment. Conversely, failure to diagnose and treat increases the likelihood of poor outcomes.

Well-designed studies have shown that the early and active treatment of disease in the asymptomatic phase has profound lifetime benefits. For instance, the Hypertension Detection and Follow-up Program³ demonstrated the reduced mortality derived from the early identification and treatment of hypertension with benefits occurring in those managed closely with inexpensive therapies. The Diabetes Control and Complications Trial⁴ showed that early and effective management of blood glucose levels for patients with type 1 diabetes reduced long-term risk for neuropathy, retinopathy, and nephropathy. The West of Scotland Study⁵ showed that patients with coronary heart disease and risk factors had lower mortality if their low-density lipoprotein chole-

sterol levels were managed actively. Targets for secondary prevention decreased with successive clinical studies, and targets for primary prevention of heart disease followed suit.

The seventh Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) specifies that even the patient with normal blood pressure should be counseled about lifestyle modification to avoid later life development of high blood pressure.⁶ The JNC 7 urges clinician empathy for a patient who generally feels well. The implication is that some physicians will convince a patient with a silent disease to change dietary and exercise habits and perhaps take daily medications.

The ever-expanding repertoire of interventions, screening tests, vaccines, and devices has dramatically increased the work of patient care for all physician specialties. As an indicator of this ever-expanding content, the total resource-based relative value units per Medicare beneficiary increased by 45% from 1992 to 2002.⁷ For the generalist physician, this increase has been especially intense. Providing all recommended preventive services to a panel of 2500 patients could require up to 7½ hours a day of physician time.⁸ Generalist physicians report that roughly 4 separate problems are addressed at each office visit for patients older than 65 years and even more issues are addressed for patients with chronic illnesses such as diabetes.⁹ For a hypothetical 79-year-old woman with 5 medical conditions, current clinical practice guidelines would support the use of 12 medications.¹⁰

Attaining the expected health benefits from early and effective treatment of symptomatic and asymptomatic illness will not be achievable without increasing the number of generalists. The United States is now served by highly trained but limited-scope practitioners, at the very time skillful and well-supported primary care physicians are needed. The overall workload is overwhelming the capacity for generalist care if not the individual clinicians.

This problem will only be resolved with full recognition of its origins. Because physician decision making profoundly influences health care expenditures,¹¹ the forces that affect these decisions must be addressed. Practice type and physician specialty are critical factors; both are associated with higher rates of test ordering and hospitalization.¹² Gen-

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eralists with long, continuous clinical relationships with patients tend to generate lower health care costs for their patients.¹³ Current reimbursement incentives substantially favor procedures and technical interventions and offer financial advantages for expensive care,¹⁴ thereby encouraging specialty services. The Medicare experience illustrates the paradoxical health consequences of this economic pattern. States with higher Medicare spending have lower quality of care.¹⁵ As a consequence of many economic forces, compensation for generalist physicians is roughly half or less than half the compensation for nearly all specialists.¹⁶

The Centers for Medicaid & Medicare Services (CMS) determines the relative payment rates for virtually all federally reimbursed professional services. The resource-based relative value scale¹ was intended to rationalize physician reimbursement and to reduce federal payment disparities among clinicians by assigning relative value units (RVUs) to all physician activities and expenses. Medicare reimbursement is determined for each service code by adding the work RVU, the practice expense RVU, and the liability RVU and multiplying each by separate payment units, or “conversion factors.” All the RVU conversion factors are geographically adjusted. On average, the work RVU represents slightly more than half of the total; the practice expense RVU, slightly less than half; and the liability RVU, a small portion. The work RVU values issued by CMS have a profound effect on all professional reimbursement because most private indemnity insurance companies use the actual CMS RVU values or some derivative.

The American Medical Association (AMA) sponsors the resource-based relative value scale update committee (RUC) both as an exercise of “its First Amendment rights to petition the Federal Government” and for “monitoring economic trends . . . related to the CPT [Current Procedures and Terminology] development process.”¹⁷ Functionally, the RUC is the primary advisor to CMS for all work RVU decisions.

The RUC has 30 members (the chair only votes in case of a tie) with 23 of its members appointed by “national medical specialty societies.”¹⁷ Meetings are closed to outside observation except by invitation of the chair. Only 3 of the seats rotate on a 2-year basis. Other members have no term limits. Seventeen of the permanent seats on the RUC are assigned to a variety of AMA-recognized specialty societies including those that account for a very small portion of all professional Medicare billing, such as neurosurgery, plastic surgery, pathology, and otolaryngology. Proceedings are proprietary and therefore are not publicly available for review. Traditionally, more than 90% of the RUC’s recommendations are accepted and enacted by CMS (http://www.ama-assn.org/ama1/pub/upload/mm/380/rvs_booklet_07.pdf). As the catalog of billing opportunities expands, the total number and, importantly, the type of RVUs delivered each year have increased. From 1992 to 2002, the number of evaluation and management services as measured by RVUs increased 18% while the number of nonmajor procedures increased 21%,

and the number of imaging services increased 70%.¹⁸ The resource-based relative value scale system “defies gravity”¹⁹ with the upward movement of nearly all codes. In 2006, based on RUC recommendations, CMS increased RVUs for 227 services and decreased them for 26.¹⁹

Until 2007, CMS depended on historical survey data collected by the AMA and specialty societies that were heavily influenced by previous practice patterns and payment biases to determine practice expense. The 2007 Medicare Payment Advisory Commission²⁰ report outlined reimbursement “distortions” that emerged from this model through the overvaluations of practice expenses that incentivized certain procedures, the undervaluations that made certain professional work financially unattractive, and misevaluations that led to “unwise” expenditures by Medicare. Ginsburg and Berenson¹⁹ calculated that failure of CMS to accurately adjust practice expense RVUs to reflect true equipment use and financing costs, acceptance of revised practice expense RVUs for 8 specialty societies, and congressionally mandated budget neutrality requirements reduced the January 1, 2007, increase in evaluation and management reimbursement from 20% to 6.5%.

The CMS intends to initiate a new method to more accurately calculate practice expenses, and there will likely be a modest shift in practice expense RVUs from procedures to evaluation and management services.²⁰ However, new distortions of practice expense may replace those of the past because the new practice expense RVUs are determined in part by work RVUs. The inaccuracies of one relative value system are carried into another. The enormous practice expenses related to the matching of medications to formularies required by Medicare Part D largely falls on the generalist practitioners, but the increased office expenses have yet to be included in the practice expense discussions.

The RUC has powerfully influenced CMS decision making and, as a result, is a powerful force in the US medical economy.¹⁰ Furthermore, by creating and maintaining incentives for more and more specialty care and by failing to accurately and continuously assess the practice expense RVUs, the decisions of CMS have fueled health care inflation. Doing so has affected the competitiveness of US corporations in the global market by contributing to years of double-digit health care inflation that have consistently increased the costs of manufacturing and business in the United States over the last decades.

The continued and sustained incentives for medical graduates to choose higher-paying specialty careers and for those physicians in specialty careers to increase income through highly compensated professional activities have been associated with the dwindling of the generalist workforce. The lack of incentives for medical graduates to choose generalist careers in internal medicine, family medicine, and pediatrics has had a profound effect on the workforce mix and, ultimately, US health care expenditures.

Residents are choosing not to enter the generalist fields. For instance, among first-year internal medicine residents, less than

20% have interest in pursuing careers in general internal medicine.²¹ Past trends indicate that only slightly more than half of these residents continue this commitment to general internal medicine to the completion of residency.²² If this continues, as few as 10% of those training in internal medicine will to work as general internists.

Other factors contribute to the decline of the generalist workforce including the increase in administrative expectations from new quality improvement initiatives, record keeping inefficiencies, inadequately compensated disease management, and liability concerns.²³ As a result of the economic forces and the practice challenges, medical student and resident interest level will likely not sustain the generalist base beyond the next decade or so.

The generalist workforce crisis demands a system for reimbursement that reflects the dynamic and changing nature of medical practice. Physicians and payers have important roles. The relative value of clinical services should be determined by physicians, but they must accept federal oversight and accountability mandated by statute. The CMS should continually assess financial aspects of practice so expenses accurately reflect the true costs of changing clinical practice patterns and do not create undue incentives for overutilization or underutilization. The current mechanism fails to provide sufficient checks and balances and is skewed and dysfunctional.

The Medicare Payment Advisory Commission, a nonpartisan advisory panel to Congress, has identified the 4 dimensions of the professional services health care economy as physician reimbursement, workforce composition, expenditure management, and clinical effectiveness and quality.²⁴ Without a robust, well-supported, appropriately compensated, and self-sustaining generalist workforce, the majority of the US population will not be able to benefit from the powerfully effective interventions for the asymptomatic patients whose only contact with the health care system is through generalists. Furthermore, broad and affordable universal access to health care will not be possible without a solid base of generalists who can deliver care and organize appropriate referrals.²⁵

The medical profession needs to reformulate the way the value of clinical services and the infrastructure expenses of practice are determined, needs to make the process open and accountable, and needs to solicit input and oversight from those who have the health of individuals, the nation, and the economy as their highest priorities. The resource-based relative value scale system originally developed to achieve full value for cognitive services currently threatens the sustainability of the generalist base. As a result, a large portion of the population will lose access to the continuous and personalized care provided by generalist physicians whose repertoire of clinical skills and interventions coupled with access to specialty and diagnostic

services are essential for ensuring efficient and effective health care delivery.

Financial Disclosures: None reported.

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Health Fund Board Primary Care Renewal

David Labby, MD, PhD
CareOregon Medical Director

12/12/07



CareOregon

What I'm going to talk about...

- Who we are...
 - Largest Medicaid managed care plan
 - Quality As A Business Strategy
- CareOregon's experience in helping to build Primary Care Homes...
 - Model integration
 - Model implementation

Medical management changes:

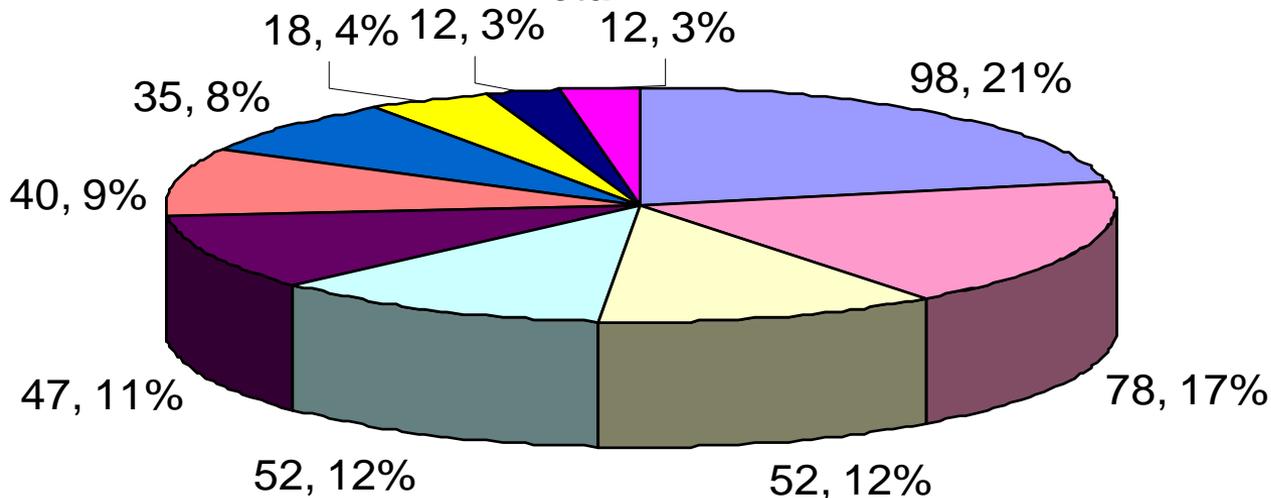
In 2003 we ramped up our internal complex care case management program...

- Johns Hopkins predictive software, ACGs
- Effective in decreasing cost and improving functional outcomes.
- Multi-disciplinary team based approach to care coordination and management.
- Improving health is about more than medical care...

Snapshot of our CareSupport population

Cases by Primary Condition as of 9/26/07

Total: 444



Major Mental Illness

Diabetes

Depression

No Primary Condition

Chronic Pain

CHF

Substance Abuse

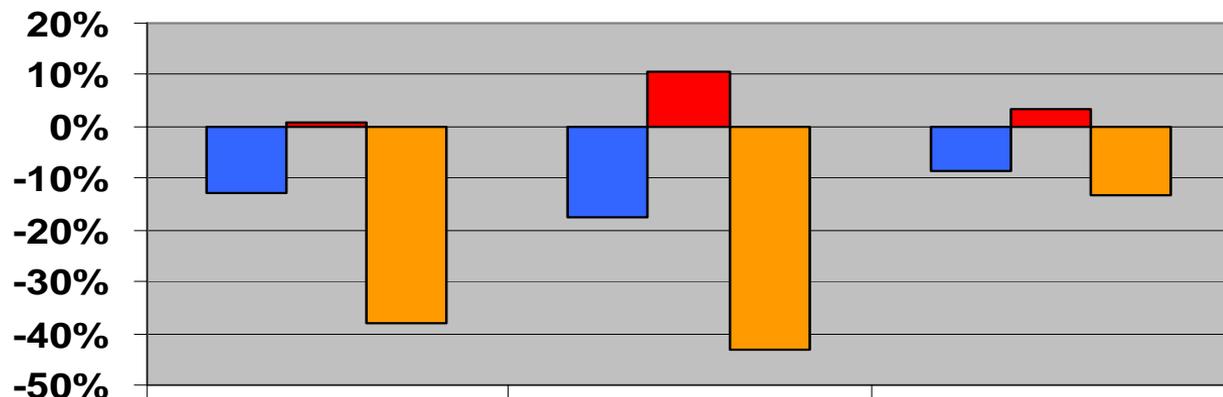
COPD

Asthma

High Risk Maternity

Where have we reduced costs?

Utilization Change 2004 vs. 2005



| | %PMPM diff | %Hosp diff | %ED diff |
|-------------------|------------|------------|----------|
| ■ Brief CM (2726) | -13% | -17.48% | -8.65% |
| ■ No CM (73643) | 1% | 10.82% | 3.33% |
| ■ CM (447) | -38% | -43.17% | -13.11% |

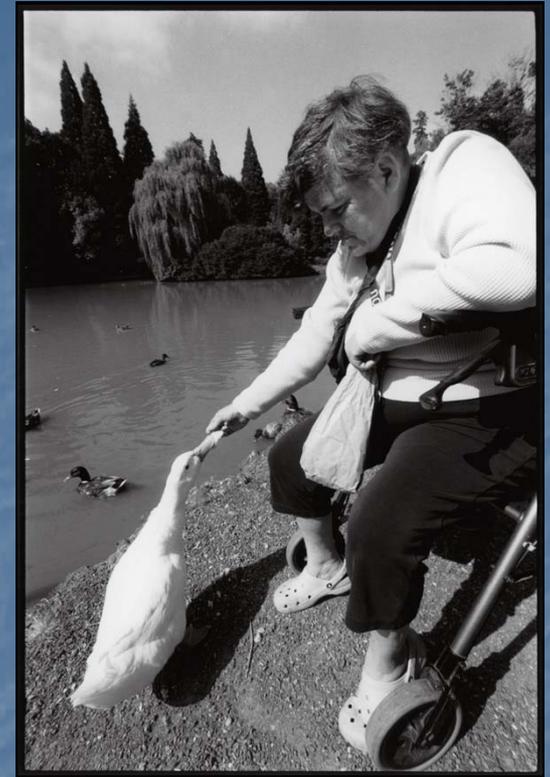
CareSupport: Cost Savings



| Risk | Yr 1 pmpm | Yr 2 pmpm | Hospital | ED | Paid Change |
|-------------------------|--------------|--------------|----------|------|-------------------|
| High Risk Member | \$3712 | \$2016 | -41% | -7% | \$1.86 Million |
| Lower Risk Member | \$1085 | \$559 | -33% | -13% | \$1.66 Million |

What we've learned...

CareSupport works well for a limited population...



But how do reach more people?

Critical Partnerships...



Care Support and System Innovation Program (CSSI)

- Board supported.
- Quality Improvement Funding Initiative.
- Opportunity to partner with our provider community to enhance care and learning.
- Provide dollars and now more technical assistance.

Key Transformation Components from SCF:

"Your work is not your schedule, but the health of the population you serve."

- Team based care
 - High functioning clinician, Case Manager, CMA, BH team
- Panel Management
 - Knowing panel member needs, proactive care
- "Customer" Driven Care
 - Rich stakeholder feedback on values, performance
- Direct Access
 - Removing barriers to communication, visits
- Integrated Behavioral Health
 - Co located solution based interventions

- Plus: Commitment to process improvement and excellence
 - Dedicated Process Improvement leadership and staff, Development Center

CSSI 2006: Waiting is not an option

Goal

The goal of the CSSI Program is to foster a culture of evidence-based practice and continuous improvement in CareOregon provider organizations, helping to empower providers over time with the skills, knowledge and resources to be able to create the substantial change necessary to meet IOM goals.

Project proposals will be evaluated based on each team's experience and demonstrated ability to create change in their organization, with each new project demonstrating improved design, outcomes reporting, institutional commitment and capability.

Funding Categories and Eligibility Criteria

There are four categories of CSSI funding: ambulatory care-based projects, hospital-based projects, innovation projects, and projects solicited by CareOregon.

1) Ambulatory Care: Population Based Projects-- Improving Care for One Hundred to One Thousand Lives

The CSSI 2007 focus for Ambulatory care-based projects is improving the lives of significant populations of CareOregon members and other patients. Projects will be expected to impact defined groups of patients based on evidence-based care and/or established best practices at one of the following levels:

- a) Whole system primary care delivery redesign including ALL of the following:
 - Patient/ customer driven care
 - Same day access
 - Proactive panel management
 - Team care delivery (clinician, case manager, etc)
 - Integrated behavioral health

CSSI "PCR" Track Pilot Sites

- Virginia Garcia – Cornelius
- Central City Concern
- OHSU Richmond
- Legacy Internal Medicine
- Multnomah County Health Dept

Use Established Change Methods

- Basic Tools for creating change: “Model for Improvement”
 - Know what you are trying to improve
 - Test small changes that can be done quickly, with simple measures
 - Keep building on small changes: be ambitious, but be patient

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



Team Based Care: Change Ideas

| SCF Specific Changes | Change Ideas |
|--|---|
| Allow team time to consult, review care | Block out time at beginning of sessions for team huddles, clinician calls to patients, chart review |
| Look at daily schedules to find visits that could be calls by RN or MD | AM team huddle to review next 3 day schedule and triage work |
| Create Care Plans on team basis | AM team huddle to review new care plans for proactive or follow up care |
| Establish target conditions, interventions | Initially focus on one or two target areas to refine processes, adding others incrementally |
| Allow clinic visits to all team members | Schedule RN, MA or BH visits depending on need |

What we know...

- Primary Care Homes are being developed and renewed in Oregon.
- There is general agreement that these models provide better, cost effective care.
- The Health Fund Board can be a catalyst for the spread of primary care homes.
- Oregonians would benefit from access to a care home in their community.

Additional Information

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CareOregon

The Trust for Healthcare Excellence

“The Trust for Healthcare Excellence promotes the collective efforts and conditions necessary for health and healthcare excellence.”

Summary

The Better Health Initiative, Boulder, CO, June 15-16, 2007

and

The Oregon Better Health Initiative, Portland, OR, July 26, 2007

*“Destiny is not a matter of chance, it is a matter of choice;
it is not a thing to be waited for, it is a thing to be achieved.”*

William Jennings Bryant

“The best way to predict the future is to invent it.”

Alan Kay, 1971

These notes summarize the content and discussion at The Trust for Healthcare Excellence’s Better Health Initiative meeting in Boulder, Colorado June 15-16 as well as the Oregon Better Health Initiative meeting July 26 in Portland.

Objective and Purpose

The objective of the Better Health Initiative is to foster a unified voice and grassroots action plan among advocates who believe in a systematic, evidence-based approach to health care reform. Because of its critical central purpose in high performing health systems, and because of its current weak position within the US health system, our initial focus is on primary care and its advocates.

The purpose of these meetings was to:

- Present a set of Guiding Principles for Healthcare
- Discuss the data that informs health system design
- Consider how primary care and its advocates can speak with a more unified voice and establish a plan for stronger, more cohesive primary care advocacy

To achieve the depth of change necessary in US healthcare, we believe that more significant progress is likely to be achieved by working at the state rather than national level. We believe that the direct engagement of front-line care providers in a positive process of and advocacy for deep system reform is important.

Definition of 'primary care'

“Primary Care” represents a team of healthcare professionals providing first contact longitudinal, integrated, relationship-based, “whole person” care for all aspects of health, both mental and physical – the ‘medical home’.

While there are a variety of reactions to the term “primary care”, it is the most recognized label for the functions that general pediatrics, internal medicine, and family medicine clinicians and teams provide. In discussing primary care, we assert that the primary care needed in the US is a team-based, multidisciplinary function supported by appropriate information technology and processes that allow it to provide comprehensive, longitudinal, coordinated, relationship-based care.

We acknowledge that existing primary care needs to evolve significantly to become this envisioned, comprehensive function. We also acknowledge that not all primary care is alike – that primary care design should be determined by the needs of the population served.

The Imperative

While the problems of quality of care are well known, the continually rising cost of healthcare represents an increasing threat to our communities. Healthcare spending is increasingly diverting funds away from other areas such as living wages for workers, public education, and other social services. In 2006 healthcare spending made up 17% of the US GDP and it is increasing approximately one percentage point every three years.

There are powerful economic currents that serve as challenges to healthcare reform: many individuals and institutions doing quite well economically within the current system, and we exist within a society that tends to value individualism (me) and individual good over the public (we) and public good. However, a focus on institutional/organizational finances and on individuals while ignoring the cost to society and the impact of not considering the public good is taking an increasing toll on our communities.

Former Oregon Governor Dr. John Kitzhaber offered three take home points:

- 1) We must control costs in order to avoid significant economic damage to our communities.
- 2) We cannot control costs by narrowly defining our current situation as an insurance problem, but rather we must rethink the “benefit” and delivery system design.
- 3) We are not powerless - there is a great deal we can accomplish working together.

The Process

It is essential to define what we want healthcare to achieve before we define what the system should look like. Once we define healthcare’s purpose, we should use existing data to provide guidance on optimal health system design.

Both are possible today. We discussed the proposed Guiding Principles for Healthcare and the data that gives guidance to health system design:

Guiding Principles for Healthcare

- 1. The objective (purpose) of our health system is health as measured at the individual, family, and community levels.** *This does not say that the purpose is 'access to health care', but rather the purpose is in fact 'health'. Health care is a means to health. We need to measure health at the individual, family, and community level. There can be a natural tension between a focus on individual/family health and community health - determining the right balance is critical.*
- 2. Individual and community health are public assets. Universal access to basic health services is essential to the well-being of our workforce and our communities.** *As a public asset, it is economically advantageous (less expensive) to have a healthy public – employers benefit from having a healthier work-force and through less cost-shifting of healthcare dollars. We as individuals and our communities benefit by reducing the direct and indirect costs of poor health and disability. Given that we will always have limitations on healthcare spending, clearly defining the “basic health services” necessary to maintain a healthy public is crucial. The positive impact of public dollars can be maximized by directing them to those strategies that benefit everyone, both directly and indirectly.*
- 3. Public resources should be allocated in a way that maximizes the health benefit across the population.** *Our focus is on public resources because we acknowledge that individuals can spend their own discretionary income to purchase additional health services. However, since health is a public asset, public resources should be allocated to maximize the asset, much like public education. This will require a social rebalancing of perspective on health care that re-includes community and public good in addition to individual good. It requires that we also begin assessing new healthcare technologies not just from the perspective of individual benefit, but from the perspective of public benefit. We have examples to build upon including public education and transportation systems.*
- 4. Decision-making about the expenditure of public resources should be evidence-based and transparent.** *Public resources will be used to provide services that have proven effectiveness. While some will see this as rationing, since public resources for healthcare are and will always be limited, it is necessary to decide what is covered and what is not. How services are assessed and the decision making about the expenditure of resources will be transparent to the public. Not pursuing this principle means that we retain and accept the current default – implicit rationing that favors some over others.*
- 5. Health care services should be coordinated, integrated, and organized within the community to provide longitudinal care for comprehensive mental and physical health.** *We need to shift from our current episodic disease care system toward a more*

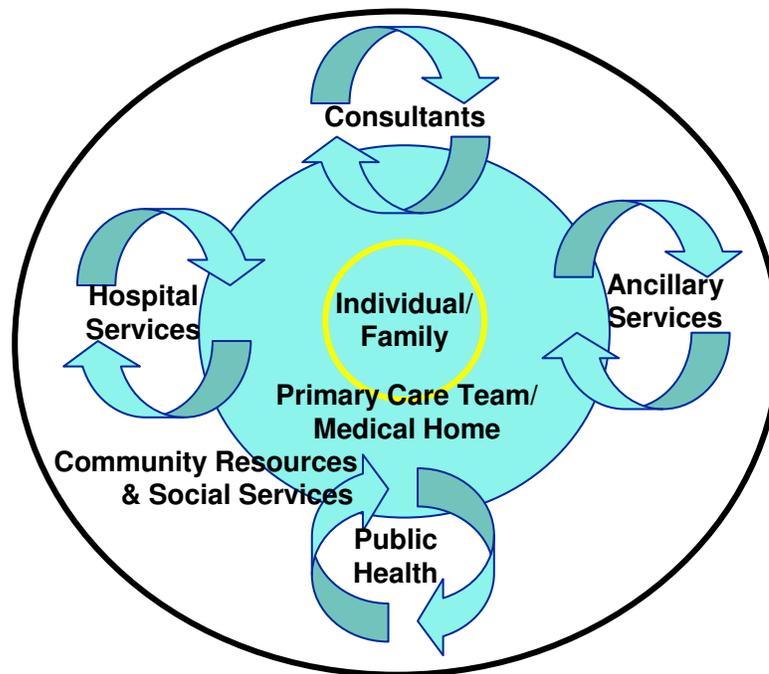
“wholistic” care system that increases focus on prevention and early detection and cares for people over time in the context of relationship through careful coordination and integration of care across providers. This principle provides the clearest guidance to health system design.

There was good discussion about the Guiding Principles and no critical disagreement. The employer community appears early on in their understanding of most of these principles – in particular, they are early on in considering the objective to be health, and health as a public asset, although there is evidence that they are moving in that direction.

It is agreed that additional information is needed to explain these principles.

Health System Design

There is extensive, credible data both from within and outside of the US demonstrating that health care systems organized around well-designed primary care produce higher quality outcomes with lower costs. While we acknowledge that all models have limitations, the following is a valid high-level, evidence-based depiction of a health system design.



There was general acceptance of the data supporting health system design that puts patients/families at the core along with primary care teams. Salient aspects of this model include the presence of primary care teams in relationship with patients and families at the core of healthcare. Other resources are intentionally organized around this core to support patient care. We acknowledge that the primary care of today will need to change significantly if it is to fulfill its necessary role, but that others in healthcare must change their work as well so that the entire system and its resources are aimed at supporting coordinated, whole person, continuous care that respects the primary relationship

between primary care and its patients. As acknowledged in the Guiding Principles, the system is oriented not just to individuals, but toward optimizing health at the community level as well.

Data by Starfield and others was presented to support this model.

Public Health and Healthcare

If the objective of a health system is health as measured at the individual, family, and community levels, and if health is a public asset, then communities (nations, states, and local communities) must have well designed, effective public health and healthcare systems. We believe that both public health and healthcare require significant reform, and that the interaction between those entities requires a much greater level of intentional design than currently exists. We value the importance of both the delivery system's and public health's role in achieving the Guiding Principles for Healthcare.

Due to the pressing economic imperative created by continual increases in healthcare spending, our initial focus is on healthcare and the delivery system rather than public health. We believe such a focus is necessary as a starting point. Plans are being made to incorporate public health (and others) into this work.

Focusing on Primary Care

In addition to establishing the principles and evidence-based system design, there was discussion about the current state of primary care. We acknowledge that the current financing environment exerts a strong influence on primary care's ability to provide necessary services, but, at the same time, we admitted that financing change alone is not the answer to the problems we face. We are supportive of current efforts to improve primary care funding which is being lead nationally by groups such as the AAFP, AAP, ACP, and AOA.

While financing changes are critical, we acknowledged that primary care – in its current form – will be challenged to fulfill its central role in healthcare. At both the medical group and local/community levels, we have serious concerns about the current state of primary care leadership, culture (beliefs, habits, behaviors), and organization in addition to its system design for chronic care management, prevention, and coordination and integration of care. While many efforts are focusing on assisting medical practices with performance improvement (i.e., implementation of the chronic care model, electronic health records), fewer national or local efforts have focused on improving primary care's leadership, culture, and organization.

Primary care (pediatrics, family medicine, and internal medicine) is heavily fragmented both in terms of its clinical organization (medical practices/medical groups) and its representation. While more unified primary care advocacy has begun to occur nationally, this has generally not been the case at the state and local levels where primary care has

frequently been without unified advocacy and a common voice. This situation has not served the cause of primary care or patients well.

For successful reform, the base of primary care needs to be engaged in a much more substantive manner in both leadership and action. The focus of the Better Health Initiative is on engaging primary care at local levels toward a new level of leadership, participation, cultural examination, and organization. To do so, we will also engage primary care advocates and advocates for evidence-based health system design. Driving such local change in leadership and advocacy will be the focus of our work and future meetings. We seek to create a convergent, consistent approach in order to mitigate the tendency within our industry toward the continual divergence of thinking and action that does not serve us well.

Next Steps

In summary, the next steps for the Better Health Initiative include:

1. Creation of the written Better Health Initiative Platform which will include a concise articulation of:
 - a. Guiding Principles for Healthcare
 - b. Evidence-based System Design
2. Action Plans to be tested at the state level to promote a new level of cohesive, grass roots advocacy to healthcare reform.

There was broad agreement that the approach outlined is a rational way of proceeding. We seek a platform for reform in which our collective advocacy – that of the many stakeholders who will be involved including primary care - goes beyond self interest.

What we hope to stimulate is a movement, in the best sense of the word engaging those at the front lines of care along with other advocates who share our vision of a better health care system. We seek to lead from the middle – calling leaders as well as front line health professionals to the vision and to the development and application of action plans.

Any movement requires consistent messaging and framing to succeed. A critical next step is to construct such a written platform that articulates our beliefs – a platform that serves as the foundation for our collective advocacy. This will be called the Better Health Initiative Platform, and particular attention will be paid to language and framing.

Next steps include:

1. Establish a writing group to articulate the Guiding Principles and evidence-based system design into a written Better Health Initiative Platform.
2. Set up a follow-up meeting in November to bring the group back together for additional work and planning
3. Initiate several state-level Better Health Initiatives to test methods of creating grass roots change in healthcare.

Next Steps for Oregon

Oregon will serve as an initial test state for promoting the Better Health Initiative. To this end, a group of local leaders have been meeting since March resulting in a meeting on July 26th as an initial step of stimulating statewide action. On July 26, approximately 100 individuals gathered for day to discuss these issues.

Follow-up steps will include the following:

1. Establish focused meetings of the following groups:
 - Primary care societies including the Oregon Academy of Family Physicians, Oregon Pediatric Society, Oregon Chapter of the ACP, and the Osteopathic Physicians and Surgeons of Oregon.
 - Residency directors for primary care specialties
 - Insurers
 - Purchasers
2. Schedule a second larger group meeting to debrief the focused meetings noted above and continue to plan and implement strategies for statewide primary care advocacy.



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Initial development at
Intermountain Healthcare

Medical homes in primary care: policy implications from Care management Plus

Presented by: David A. Dorr, for the Care
Management Plus team

Date: Dec 12th, 2007



Case study

Ms. Viera

a 75-year-old woman with diabetes, high blood pressure, mild congestive heart failure, joint pain and recently diagnosed dementia.



She sees 13 outpatient providers per year, fills 50 prescriptions per year, and patients like her represent ~50% of Medicare expenditures.

If her care is not coordinated across providers and transitions, she has an increased risk of hospitalizations and ED visits, increased risk of advancing disease, and high risk of functional decline.

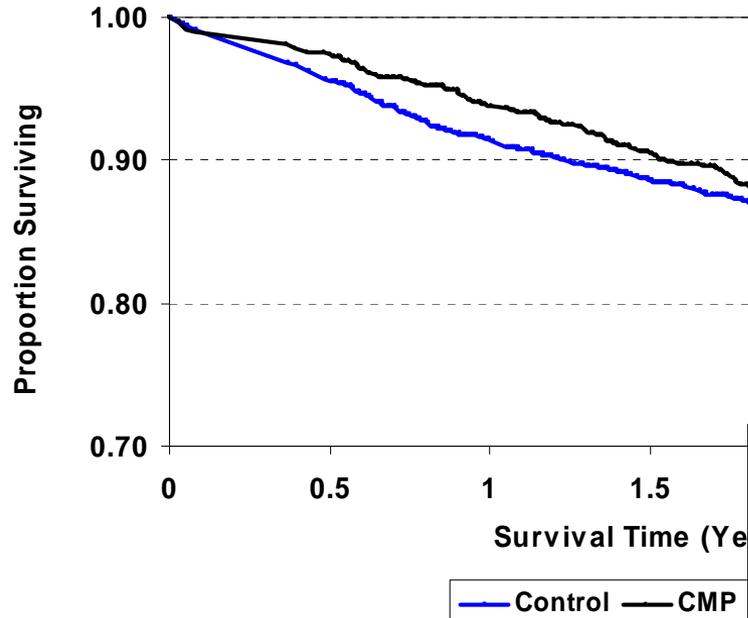
To help meet Ms. Viera's (and her family's) needs, we developed and tested a program called Care Management Plus.

In more than 40 primary care clinics in 4 states; started at Intermountain Healthcare in Utah and spread to OHSU, PeaceHealth, others ...



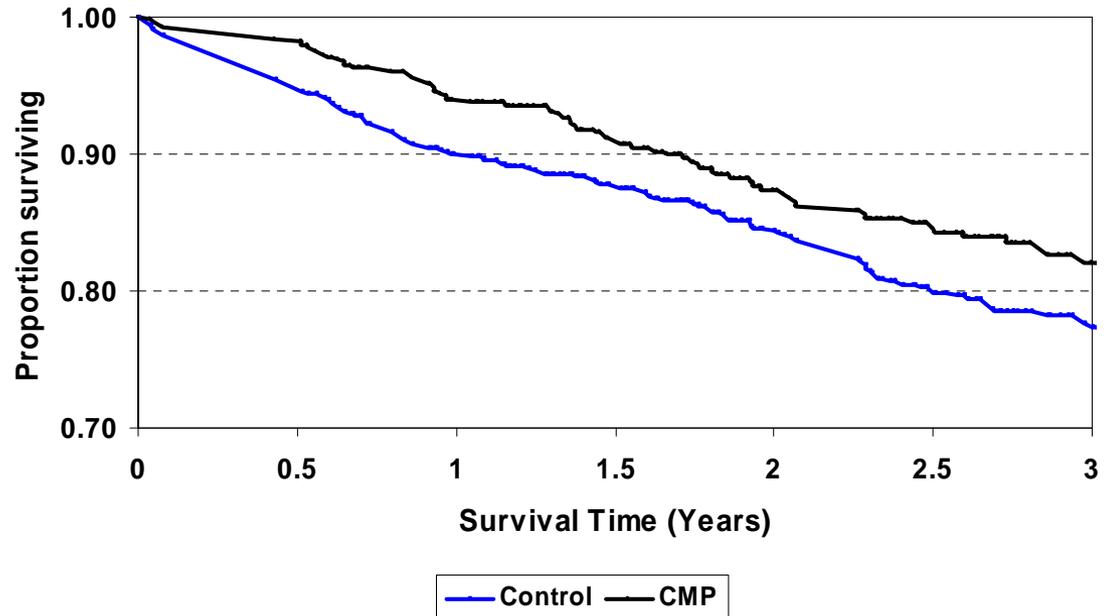
Benefits from better primary care through our study ...

1.a All Patients



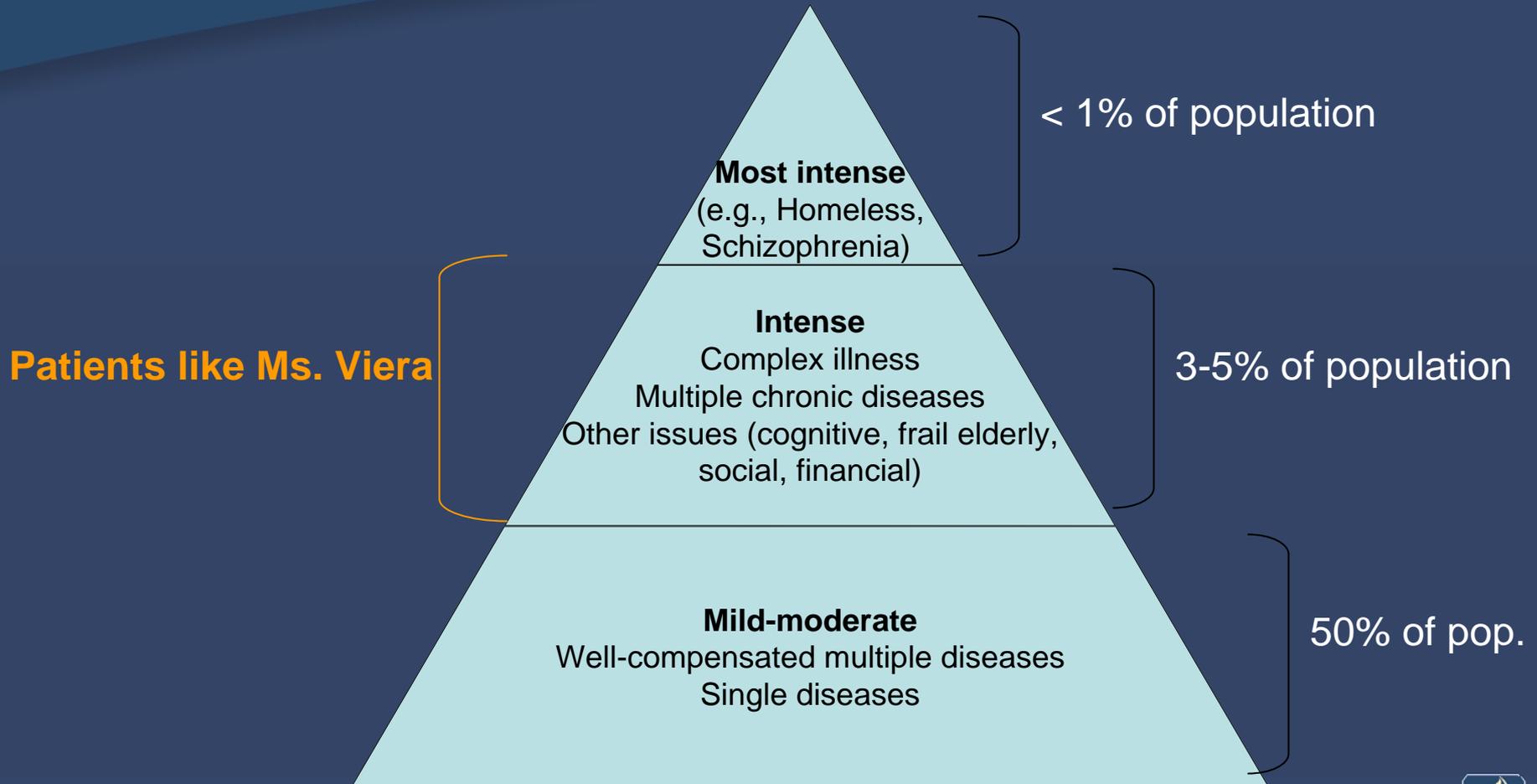
Diseases under better control
Patients / primary care team
more satisfied
Teamwork brought efficiency
gains of 8-12%
Cost savings for insurers up
to \$250,000 per clinic
Cost savings for clinic -
limited

1.b Patients with diabetes

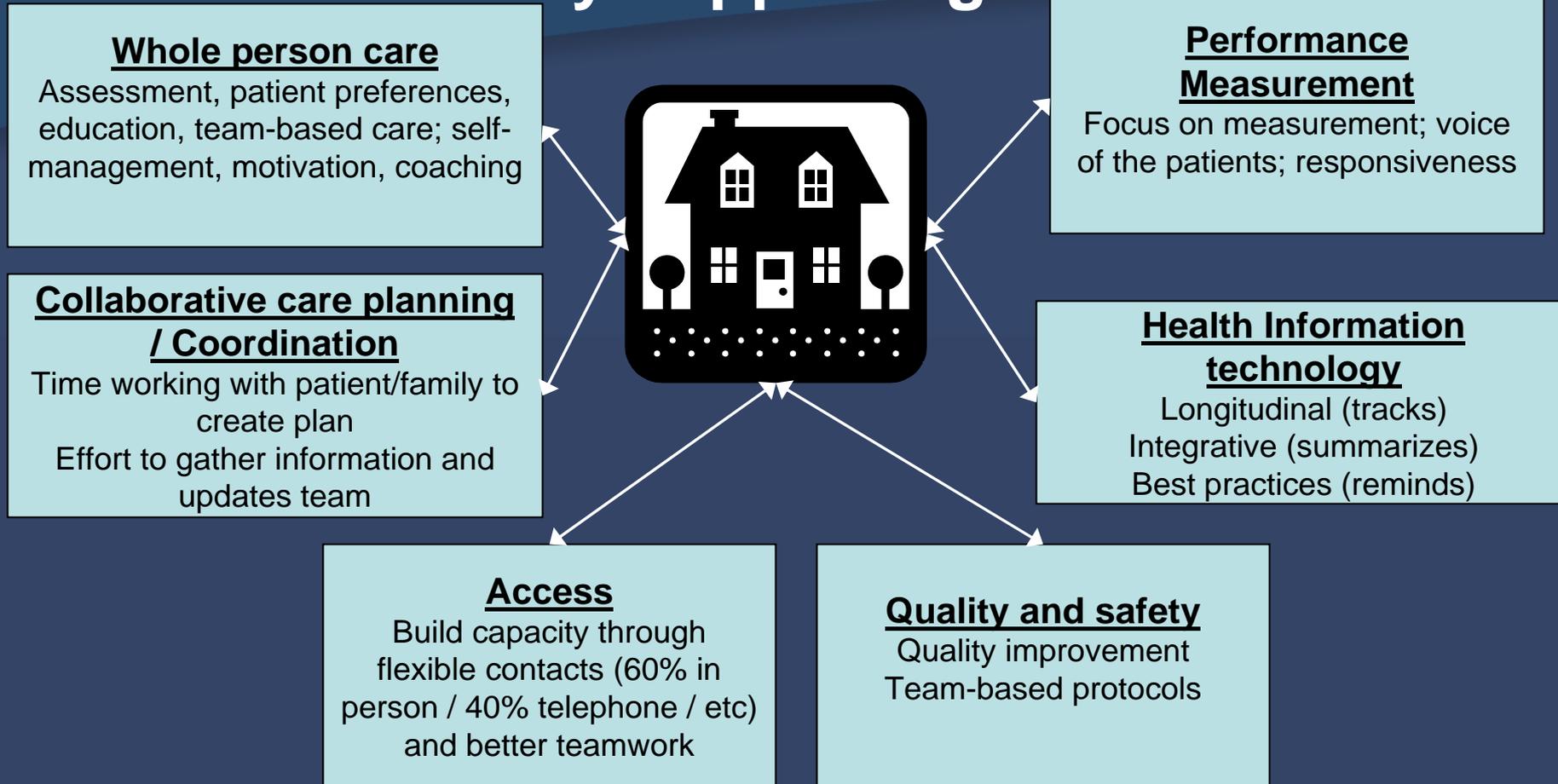


Dorr, AcademyHealth, 2006
Dorr et al, HSR, 2005
Dorr et al, DM, 2006
Wilcox, The CMJ, 2007
Dorr, AJMC, 2007

Care coordination varies by intensity and function for different populations and needs.



How can we set policy to better support a medical home? By supporting ..



(Dorr, JGIM, 2007)

Challenges in creating Medical Homes from our work

| Area | Our experience | Next Steps |
|------------------|---|--|
| 1. Reimbursement | Misaligned incentives | Thoughtful reform |
| 2. Capacity | Negatively perceived environment; change attractive | (re)Train; redesign; but mostly incent |
| 3. Reliability | Variation in clinics and implementation | Metrics (e.g., revised NCQA PPC); demonstrations |
| 4. Costs | Not a one year, zero sum game. | Demonstration with high need patients |

The Care Management Plus Team

- OHSU

- David Dorr, MD, MS
- K. John McConnell, PhD
- Kelli Radican

- Intermountain Healthcare

- Cherie Brunker, MD

- Columbia University

- Adam Wilcox, PhD

Advisory board

- Tom Bodenheimer
- Larry Casalino
- Eric Coleman
- Cheryl Schraeder
- Heather Young

(additional slides)

Redesigning metrics – National Committee on Quality Assurance Physician Practice Connection

- Access and Communication
- Tracking (registry use)
- Care Management
- Patient self-management support
- Performance reporting and improvement

PP3: Care Management (e.g.)

- Element D.1-11. For the three clinically important conditions, the physician and nonphysician staff use the following components of care management support:
 - Conducting pre-visit planning with clinician reminders
 - **Setting individualized care plans**
 - **Setting individualized treatment goals**
 - **Assessing patient progress toward goals**
 - Reviewing medication lists with patients
 - **Reviewing self-monitoring results and incorporating them into the medical record at each visit**
 - **Assessing barriers when patients have not met treatment goals**
 - **Assessing barriers when patients have not filled, refilled or taken prescribed medications**
 - **Following up when patients have not kept important appointments**
 - **Reviewing longitudinal representation of patient's historical or targeted clinical measurements**
 - **Completing after-visit follow-up**