

**THE COMMONWEALTH FUND**

## Achieving Patient-Centered Primary Care for Underserved Populations: How Medical Homes Can Promote Greater Equity in Health Care

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The Commonwealth Fund

Association of American Medical Colleges  
Workforce Research Conference  
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[www.commonwealthfund.org](http://www.commonwealthfund.org)

## Commonwealth Fund's Commission on a High Performance Health System

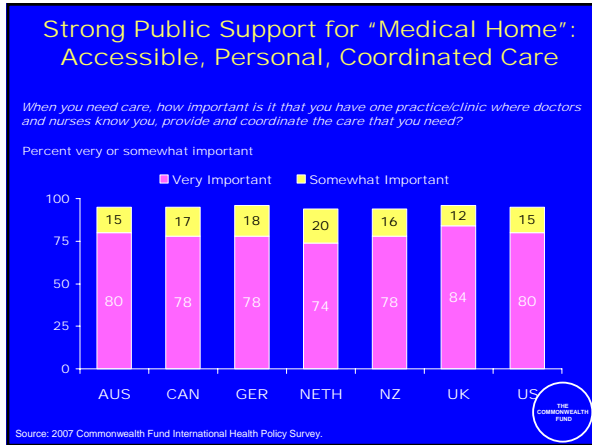
**Objectives:**

- To move the U.S. toward a high performance health care system that helps everyone, to the extent possible, lead long, healthy, & productive lives
- To the Commission, a high performance health system is designed to achieve four core goals
  - high quality, safe care
  - access to care for all
  - efficient, high value
  - system capacity to innovate and improve

Chairman: James J. Mongan, M.D.  
President and CEO Partners  
HealthCare System, Inc.



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### Examples Exist: More than One Model of Medical Home



Community Care of North Carolina



**DENVER HEALTH**  
Level One Care for ALL

**ALASKA NATIVE MEDICAL CENTER**

**UNITE HERE!**

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## Why Are Medical Homes Necessary?

**Toward Higher-Performance Health Systems: Adults' Health Care Experiences In Seven Countries, 2007**

Actual experiences with health care systems bring us light on the systemwide problems in those countries.

by Cathy Schwab, Robin Ockers, Michelle M. Dwy, Meghan Bliz Jordan Pugh, and Natalia Mendeloff

**ABSTRACT:** This 2007 survey compares adults' health care experiences in six other countries, the Netherlands, New Zealand, the United Kingdom, and the US, to all countries. The study finds that having a "medical home" that is accessible, coordinated care is associated with significantly more positive experiences. These country differences in access, experience, care, and coordination are also seen across demographic groups, with higher rates for those using medical homes in their home country. The United States stands out for its relatively lower health care costs. *Health Affairs*, Vol. 26, No. 6 (2007): 1575-1584. doi:10.1377/hlthaff.26.6.1575

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

RESULTS FROM THE COMMONWEALTH FUND 2006 HEALTH CARE QUALITY SURVEY

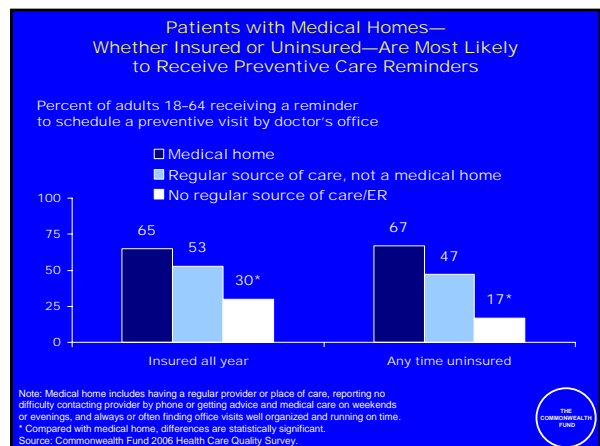
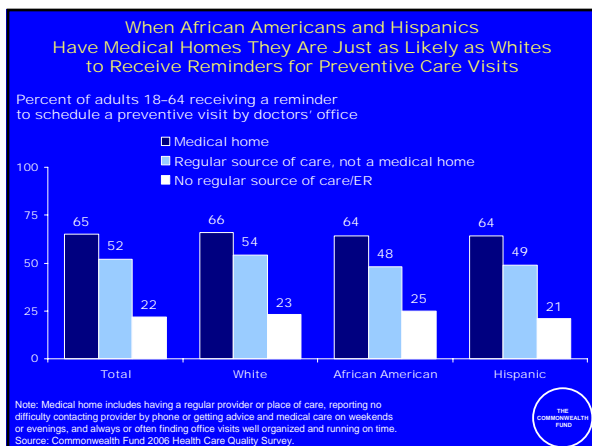
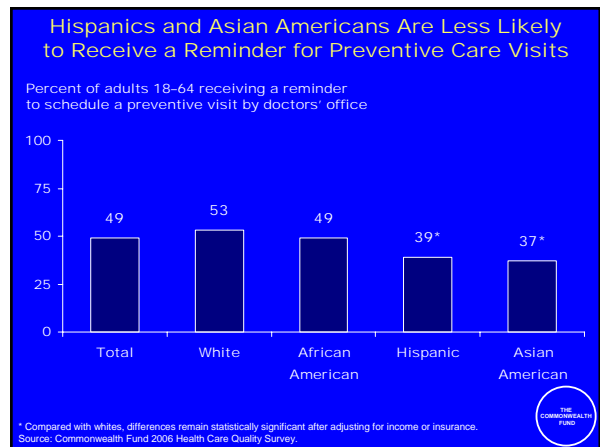
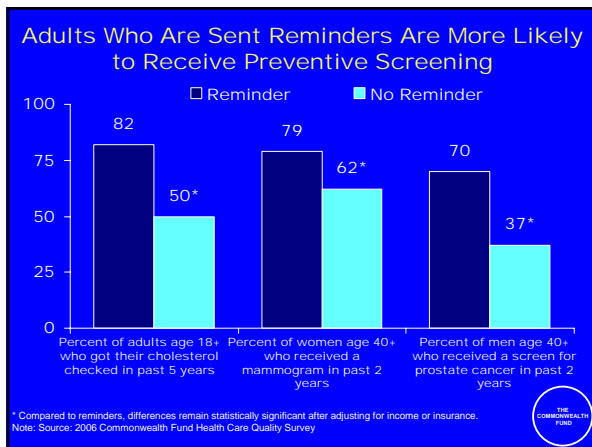
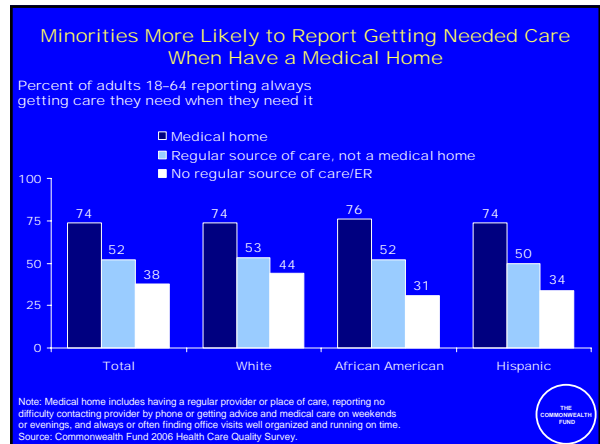
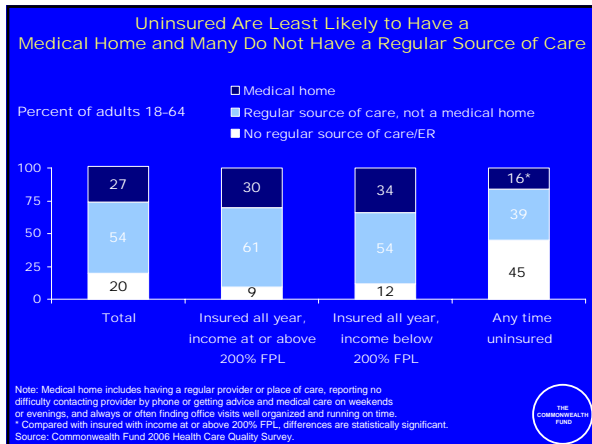
Amar C. Brad, Michelle M. Dwy, Susan E. Hershauer, Katherine K. Sles, and Karen Davis

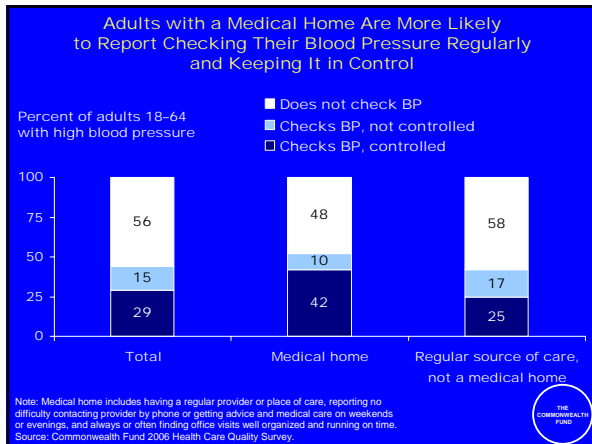
June 2007

### 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
Among those with a regular doctor or source of care . . .						
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.





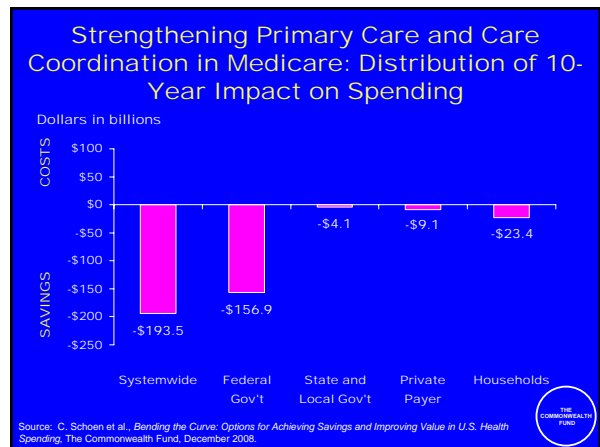
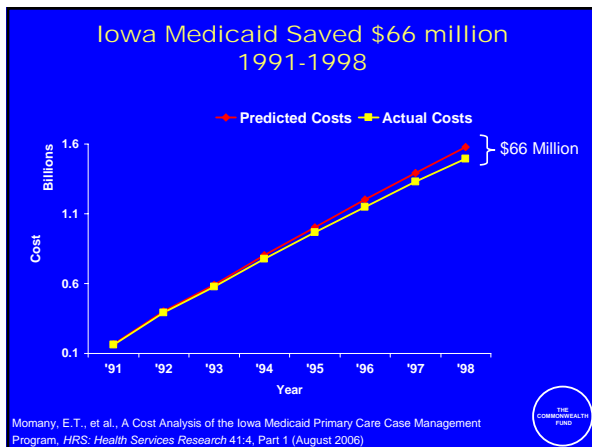
### Demonstrated Cost Savings in Medicaid: Community Care of North Carolina

**In FY 2003:**

- CCNC operating costs totaled \$8.1 million
- CCNC saved \$60 million compared to FY 2002
- CCNC saved \$203 million compared to FFS

**In FY 2004:**

- CCNC operating costs totaled \$10.2 million
- CCNC saved \$124 million compared to FY 2003
- CCNC saved \$225 compared to FFS



### Case Studies of Patient-Centered Primary Care Practices

**Common Themes:**

- **Very positive residency training experience in primary care**
- **Organizational culture and leadership committed to patient experience and team work**
- **Careful recruitment and training of staff**
- **A sophisticated information system, some electronic**
- **Patient involvement**
- **Physical space to promote team work**
- **Use of quality measures and system incentives**

Source: Susan Edgman-Levitan, Dale Shaller and Melinda Abrams. *Achieving High Performance in Primary Care: Lessons from 12 Case Studies*. Submitted to *Journal of General Internal Medicine*, March 2008.

### Develop Sustainable Model: Transforming Safety Net Clinics Into Patient-Centered Medical Homes

**Objectives:**

- To develop and demonstrate a replicable and sustainable implementation model to transform safety net primary care practices into patient-centered medical homes (PCMH)
- To achieve benchmark performance in quality, patient experience and efficiency in safety net primary care practices

## Safety Net PCMH Initiative



### Year 1: 2008

- Planning and Development (6 months)
- Region and site selection (6 months)
  - Through RFP, select 4 regions from across the country

### Years 2-5: 2009-2012

- Implementation of demonstration
  - Provide technical assistance
  - Policy development

\$6.7 million over five years, separate resources for evaluation



## Evaluations of PCMH Demonstrations

- Rhode Island (Meredith Rosenthal/Harvard School of Public Health)
- Emblem (Judith Fifield/University of Connecticut)
- New Orleans (Melissa Herrmann/ICR; Diane Rittenhouse/UCSF)
- Safety Net Initiative (Marshall Chin/University of Chicago)
- TransforMED National Demonstration Project (Carlos Jaen/University of Texas Health Sciences Center, San Antonio)

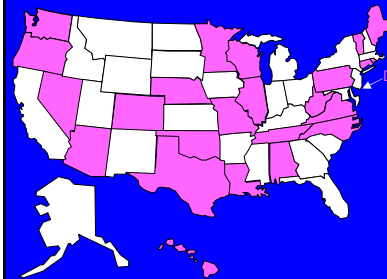


## Other Fund Work on PCMH

- Cost of PCMH (ACP and Urban Institute)
- Policy to Promote Medicaid and SCHIP (NASHP and PCPCC)
- Standardized measures to recognize and qualify PCMH (National Committee of Quality Assurance)



## 24 States Self-Report Efforts to Promote Medical Home in State Medicaid and SCHIP



Highlighted states self-identified as participating in one or more of the following:

1. Striving to improve medical home availability
2. Having legislative authority or mandates furthering the availability of the PCMH
3. Mentioning establishing MHs in their Medicaid Transformation Grant applications to enhance IT capacity to further the MH
4. Dedicating state resources to support medical homes

Source: Kaye, N., Takach, M., Preliminary State Scan Summary Results, Unpublished data (1/25/08)



## Acknowledgements



Anne Beal,  
Assistant Vice President  
Quality of Care for Underserved  
Populations



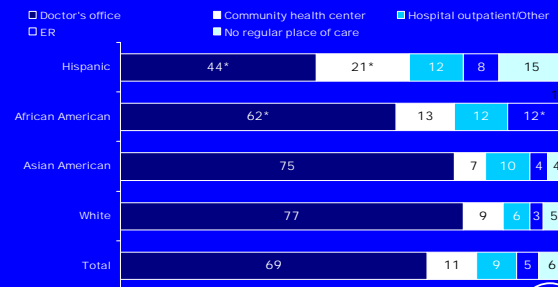
Elizabeth Hodgman,  
Program Assistant,  
Patient-Centered Primary Care  
Initiative

Visit the Fund at:  
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## Hispanics and African Americans Are More Likely to Rely on Community Health Centers as Their Regular Place of Care

Percent of adults 18-64



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



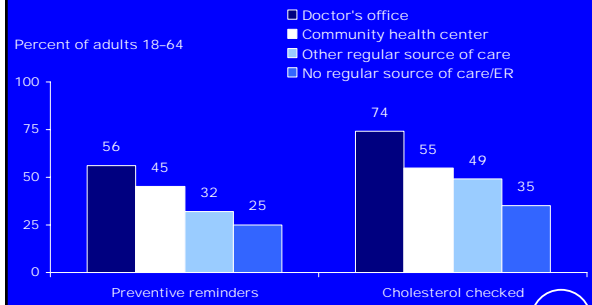
Indicators of a Medical Home  
by Usual Health Care Setting  
(adults 18-64)

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.



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.

