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((Crosstalk))

Stephen Schoenbaum: Hello, we're going to get started.

Hello.

Okay, I'm Steve Schoenbaum. I'm Executive Vice President for Programs at the Commonwealth Fund.

You can't hear me. I can hear you.

Can you hear me now? Oh, it's amazing.

Okay.

But the speakers are working over there? Okay.

On this side too?

Great.

I'm Steve Schoenbaum. I'm Executive Vice President for Programs at the Commonwealth Fund and I'd like to thank all of you for coming and on behalf of the fund, I'd like to welcome you to this briefing.

Now, as many of you already know the Commonwealth Fund is a private foundation. We're based in New York but we have national scope and activities and we were founded in 1918 by Anna Harkness and we support independent research on health and social issues.

Two years ago, the fund's board of directors formed our commission on a high performance health system and the objectives of that was to help the nation move toward a high performance healthcare system and achieve better access, improve quality, and greater efficiency of care and with a particular focus on those who are most vulnerable to the income, minority, status, health, or age.

In 2006, our program on quality of care for underserved populations performed a national survey on quality of care and we're here today to present some of the findings from the survey in relation to reducing disparities and promoting equity in healthcare.

You're going to hear today in the report called "Closing the Divide" how multiple factors are related to providing better quality of care for all Americans and in particular, you'll be hearing about the important roles of insurance coverage and medical homes.

We are very fortunate to have a superb panel of discussions that include Dr. Garth N. Graham, who is Deputy Assistant Secretary from Minority Health in

the Department of Health and Human Services, Dr. Dora Hughes, who is Healthy Policy Adviser to Senator Barack Obama and Dr. Anna Maria Izquierdo-Porrera, who is Medical Director for the Spanish Catholic Center for Catholic Community Services.

To lead off Dr. Anne Beal, who is our Assistant Vice President and Head of the Funds Program on Quality of Care for Underserved Populations is going to present some of the findings from the 2006 Commonwealth Fund Quality of Care Survey. She'll then be followed in the - by the discussions in order which I mentioned them and then I'll moderate and open Q&A session and hope all of you will feel free to participate.

Anne?

Anne Beal: Thank you, Steve.

So as Steven mentioned, the Commonwealth Fund is focused on issues of healthcare quality and access within (unintelligible) to some vulnerable patient population.

And one of the things that I think particularly important about the survey that we did for this particular project, I'm sorry, is that this is actually a national survey of patients themselves asking people about the quality of care that they received.

And so we opened the surveys asking about issues of access, asking about cost of care, we do physicians of survey but this is actually a physician - survey of patients who are really giving us an opportunity to understand about the quality of care that they receive.

And so as Steve mentioned, this was a survey that was conducted in 2006 and we had a particular emphasis on minority and lower income communities because we wanted to make sure that the people who live in those communities will - were well represented in this study and so that the analysis that we were able to conduct will really be able to reflect the quality of care that they receive.

So today's results are really based on analysis that we did of 2,800 respondents who are between the ages of 18 and 64 and we selected those age group because as many of us know, those who are over 64, the majority of people, will have access to care through Medicare but what we really wanted to do is we try to look at the issues of access and quality, particularly for working age people.

One of the things that I want to underscore is that this was very much a group project and I want to thank my colleagues at the front who worked together with me on this project, many of whom are here in the room, particularly Dr. Michelle Doty who's our Associate Director of Research and she's also available to answer questions for us today.

So the first point is that as we start to look where the disparities, we found that minorities, particularly Latinos and African-American, are much more likely to be uninsured. And again, these are not new data. We've been able to see this for years and years that particular minority populations are at risk for like in healthcare coverage.

And so one of the challenges when we do start to talk about issues of healthcare disparities, the question that I often get is, "Well, is this really a function of income or is this a function of lack of insurance coverage or are there issues in terms of health disparities that are really only related to race?"

And so clearly because we do know from these data as well as with some report from years that minorities are much more likely to be uninsured than I think that these are very fair questions.

However, if you take the time to look through the report and look at most of the analysis that we did, one of the things that we did is we control for insurance in all of our analysis so when we look for statistical significance, you'll notice that there's a byline which says that these analyses controlled for income and insurance when appropriate.

Because what we're trying to do is isolate and say, "When we see differences, are they really differences just based upon race or is it a function of these other factors with income and insurance?"

And especially what we find is that even when you look at it with this control that in terms of measures of getting the care that you need, in terms of preventive care measures such as receiving preventive care reminders and cholesterol screening, in terms of management of chronic diseases, so control of blood pressure.

We found that there were disparities in all of those measures and that they were significant even when you control it for income and for insurance.

But one of the things and I talked to someone earlier today is that in addition though to making this a report we should describe disparities, what we wanted to do is to talk about, well, what is it that we can try to do about addressing disparities and didn't want it to be the same story of disparities exist, disparities are bad and we should do something about it. What we wanted to

do with this report is to try to give a little bit of thought as to what that something should be.

And so we had basically built on some of the work in this concept of a medical home which has actually been in the literature for a number of years. The concept of a medical home is basically a place where people can go where it is the primary place where you get your care, there is someone there who's your regular provider, it is a place which provides continuous care which coordinates your care with which you have a longitudinal relationship, it's easy to get into.

And so we thought that if we could try to create and measure this concept of a medical home, might we be able to see that it has an impact on disparities and care.

As an FYI, this was a concept that really began about 20 years ago in the pediatric community and I am a pediatrician so you should know that about me.

But also, we're now seeing that it really is being taking up now by many primary care professional organizations, so the American Academy of Family Practitioners, ACP, the American College of Physicians, they are consortium of professional organizations which are really saying that this should be a standard of care.

We're also seeing and discussed within safety net community so we're seeing discussions in the community health centers, we're seeing discussions among safety net providers in general that we really need to try to provide high standards of care and the medical home is a particular model.

So one of the questions that we received when we really start to send this report as we get questions is, exactly what is a medical home?

And so when I talked to about what the concept of the medical home but I want to spend some time talking to you about exactly how we measured it.

So the very first question that we asked people is, "Do you have a regular provider or a regular source of care?"

And so you'll see here that about 80% of respondents said, "Yes, that is the case." And then among those who had a regular provider or a regular source of care, we basically asked just three basic questions.

One, "Do you have any difficulty getting to your provider by telephone?"

Two, "Do you have any difficulty contacting your medical provider in evenings or weekends?"

And then three, just a general global question of, "When you go to visit your doctor, are their offices generally well organized and running on time?"

And so when people were able to say yes to all four of those measures, what we found is we described that as having indicators of a medical home and what we found is that actually only about one of four adults in the United States say in fact that their healthcare is really provided to them by a center which seems to have indicators of a medical home.

In particular, one of the things that we saw that there were significant racial differences particularly with Latinos being much less likely to say that they had all four indicators of a medical home.

And one of the things that I want to bring your attention to is the second line which talks about not difficult to get care or medical advice after hours. This is one of the areas where people were least likely to say that they had no problem.

So for anyone who's familiar with the literature on inappropriate use of the emergency room, one of the things that has been described time and time again when you talk to patients, "Why were you here for?" A cold or an ear infection, the kind of things which can normally be handled by your primary care provider, quite often people will say, "Well, I just couldn't get to my doctor, the doctor's offices were closed. Their office was not available".

So when we talk about inappropriate ER use, this is not so much as inappropriate because the patients want to be in the emergency room, it's inappropriate because the systems within which they're functioning are not available to them because not every kid is going to get their ear infection between the hours of 9:00 to 5:00.

And so I think that the promise of this type of model in terms of expanding care, there would be further work that needs to be done in terms of what does this mean in terms of reduced hospital patients, reduced emergency room use or does this mean in terms of the potential cost savings when people really have this expanded model of access.

But what we do see from the disparities perspective is that there are significant racial differences and that particularly Hispanics are having challenges in terms of being able to access these high performing primary care providers.

Next, we wanted to take the question look at, well what about people who lack in insurance coverage? And not surprisingly what we found is that people who are uninsured are much less likely to say that their regular providers function as medical homes.

And so what you see here is that for people who in last year said that they were uninsured at any point, only 16% of them were able to describe their regular providers as functioning as a medical home.

And the reason why I want to bring your attention to that is because if we're talking about people who are uninsured still having medical home and with that is speaking to is that there are safety net providers who are out there who are taking patients regardless of their ability to pay and yet still are able to provide all the indicators of a medical home.

And so while this is a very small portion of the care that the uninsured say that they're receiving, it's actually a critically important portion of the care which is being delivered by these safety net providers because of all the (items) that we're going to see later in terms of the benefits of having a medical home.

So the next question then that we asked is, "So, does having a medical home really matter?" Because we know that conceptually this has been something that the medical societies have been talking about for a number of years but at the end of the day what we really care about is does this improve patient care?

So one of the questions that we asked is a global question of getting the needed medical care, so we asked patients, "Can you get the healthcare you need when you need it?"

So this is one of the global assessment of satisfaction and access, it's not just about can you get an appointment but can you get your questions answered, can you get your needs met, can you get your prescriptions filled. It's just kind of like the global question of getting access to care.

And one of the things that we found is that when patients had a medical home that there were absolutely no disparities and they're saying that they were able to get the care that they needed when they needed it.

In addition, when we just looked at stratified by race and ethnicity, what we found is that in general, only half of all people said that they were able to get the care that they needed and there were in fact racial differences but when we looked at people who were in medical homes there were no racial differences.

So for me as someone who's been working on health disparities for a number of years, I was actually very excited to see these results; to finally see a system where we're not seeing any disparities in healthcare.

So this was kind of the global assessment and then the next thing that we wanted to look at was preventive care.

And so one of the things that we found when we looked at people who were sent reminders to receive preventive screening, we asked them, "Do you receive reminders, yes or no?" And then we asked them, "Have you received some of the following preventive care procedures in the last year?"

And so in this setting, we looked particularly at cholesterol screening in the past five years, women over the age of 40 who have received a mammogram in the last two years and men over the age of 40 who have been screened for prostate cancer.

And one of the things that I think is particularly important is that we really come up preventive care trying to prevent disease before it happen. And what we found is that for people who did receive reminders, there was significant difference in terms of they're having received these preventive care procedures.

Now, in terms of looking at it by race and ethnicity, what we found is that when we asked people, "Do you receive preventive care reminders from your providers," there were some racial differences in terms of receipt of preventive reminders.

Although, one of the things that I want to point out is that if we want to take the quality of care that's received by White as a standard of care, even that is not good because only half of those people said the they received preventive reminders.

So the fact is that we're really talking about what does it take to get to improved care for everybody as well as equitable care for all?

So in terms of looking at this question about receiving preventive care reminders among those who are in medical homes, what we found is after what we know racial disparities and that the rates of receiving these reminders improved for everyone, up to 2/3 of people in medical homes said that they have received these types of reminders.

And so again, is this ideal (unintelligible) because ideally we want people to be functioning at 100%, but clearly there's a difference when we go from, say, 50% of the general population up to 2/3 of those who are in medical homes

receiving these reminders and we do know that these reminders make a difference in terms of receiving preventive visits.

In addition, we looked at it in terms of people who were insured versus those who are uninsured. And again, I want to remind you that that number of uninsured people in medical homes was very, very small.

However, among those who were uninsured and did have a medical home, we saw absolutely no difference between the uninsured and the insured in terms of receiving these reminders.

And so again, what it says to us is that these safety net providers are doing their job and their job is to deliver high quality and they're delivering quality of care which is comparable to other settings.

And so I think that this is very important because in most of the days that we look at, when we look at the differences in quality received by the uninsured, time and time again we find these significant differences but here's one particular promising model where there's actually no disparity by race and ethnicity and there's no disparity in terms of insured and uninsured.

Then beyond preventive care, one other major part of what primary care providers do is they care for patients with chronic condition. And so we wanted to look at chronic condition, the most common ones being hypertension, diabetes, asthma, heart disease and these are all very common in primary care settings.

And in fact what we found in our particular study was that among the patients 18 to 64, so these are not elderly people, 43% of African-American said that they had at least one chronic condition. This is as compared to 35% of White;

so one in three White under the age of 64 have one of these chronic conditions.

So this really represents about 60 million people in the United States who really need enhanced primary care in order to manage their condition.

And so one of the things with all of these conditions is these are the types of conditions where people need to monitor themselves whether it's their blood pressure or their diet, they need to exercise, they need to know when they're having troubles or when there's a plan so that they can either self monitor or go back to their providers.

And so we asked people who have a chronic condition if they were given plans to manage themselves at home or to manage their conditions at home. And what we found out is when we stratified it again by this type of care that you have that among those who had a medical home, only 23% of them had not received a plan to manage their conditions at home.

This is as compared to about one in three of people who said that they had a regular provider but that provider didn't have the indicators that they were high functioning provider and functioning as a medical home. And obviously the people have no regular source of care or who use the emergency room as a regular source of care were the most likely to not have a plan to manage their condition at home.

Then, in addition to how one might plan to manage themselves, we also looked at outcomes in terms of chronic disease and had a specific focus on high blood pressure.

High blood pressure many of you know is one of the most common chronic conditions on the United States, is the one for which there is significant challenges in getting patients to really bring their pressure under control if the condition which is much more common particularly in African-American and Latino communities and it's one in which if patients are monitoring themselves, they're really actually able to tell us if they are well managed and so they know their numbers.

And what we've did is we asked them, one, "Do you monitor your blood pressure at home?" And then two, "Is it well controlled?" And we said specifically, "Do you have a blood pressure of less than 140/90?" And the patients were in fact able to tell us those specific numbers.

And so in fact what we found first of all is that in general about half of people do not - with high blood pressure, do not monitor their hypertension at home. But when you look at it broken down by those who have a medical home versus those who have just regular source of care that is not a medical home and I want you to bring your attention down to the lower part of the stat bar, the dark blue part which looks at the people who not only check their blood pressure but the blood pressure is also under control, that 42% of people who said that they had a medical home have their hypertension under control as compared to 25% of people who have just a regular source of care that is not a medical home.

Now, clearly this is not ideal because obviously we would want 100% or even 90% or 80% of our patients to have their hypertension under control but what it does tell me at least is that this medical home model and the way that we were able to measure and recognize it's not ideal but it shows that there's some promise, there is some way to move this needle in terms of being able to

manage hypertension which as we know is a particularly important condition in minority communities.

Then, in addition one of the other things that we wanted to look at was the question of safety net providers and access to a medical home. And essentially, what we did is we ask people, "Do you have a regular source of care?" And they said, "Yes." And then we said, "How would you describe this care, is it a private doctor's office? Is it community health center or some other public clinic? Or is it some other setting as an emergency room?"

And so based upon those responses, we're able to categorized patients into sources of care that were either doctor's offices, community health centers and public clinics or some other type of setting.

And so what we've found here is that overall, none of the different settings of care are doing particularly well being able to say that they function as medical homes.

And so some people will say, well, some providers versus others but the fact is no one is doing exceptionally well in terms of being able to function as medical home but one of the things that we talked about is the importance of this from a disparities perspective in terms of being able to support particularly community health centers and other safety net providers to function as medical homes because they care for such a large number of low income uninsured and minority patient.

And in fact, we have data in the report which show that 20% of the care which is delivered to the uninsured are delivered in community health centers, 20% of healthcare delivered to low income patients is delivered in community health centers.

And then when you look at minority patients in general, one in five Hispanics received their care in community health centers as do 13% of African-Americans as compared with 9% of Whites and 7% of Asians.

And so these are very important institutions in terms of being able to deliver high quality care to underserved patients and part of what we're calling for in this paper is to obviously support all providers to function as medical homes but particularly to focus on the safety net because they are such important providers of care.

So in summary, at the end of the day, we're really (excited) as I said is that this is not the same sad, sad story of disparities exist and we should do something about it. To me, what is very promising about this is that whether we look at it in terms of access, in terms of receiving preventive reminders, in terms of preventive care, in terms of chronic disease management throughout the whole spectrum of healthcare that we try to look at, whenever patients said that they were in a medical home, we found that there were no disparities in the quality of care that they receive.

So I think that this concept of medical home is very important and it's a very important model that we should try to promote and to replicate in a number of settings in order to try to, one, improve healthcare for everyone because as I said, some of the numbers even for the White respondents were not that good.

So this is not that we're trying to get minorities up to the same bad care that Whites are getting, what we're trying to do is improve care for everybody.

And so what we called for in the report is obviously healthcare coverage because one of the things that's clearly evident is that insurance matters, it

matters in and of itself, as well as clearly it matters in terms of who has access to these higher performing primary care providers.

Also, although we had developed these measures of a medical home, there really right now is a conceptual understanding of what a medical home is but if any of us were to walk into our doctor's offices tomorrow, would we know that we're in a medical home or more importantly not in a medical home and need to find a medical home.

And so we really need to work on trying to establish standards of a medical home particularly for use by patients in order to try to select where they're going to go for their healthcare.

And so obviously then what this also speaks to is need for public reporting of those standards so that people can say, "I want to go to this provider," versus, "Not that provider." Or if you are a payer or a purchaser of healthcare, you'll say, "Well, this one who meets the standard for a medical home, I might pay you a little bit more because you keep those patients out of the emergency room and I might pay you a little bit less because you're costing me money by sending your patients to the emergency room at night."

So in general, what we called for is really trying to promote these standards whatever they maybe and I think that there's a lot of work that needs to be done on that in all sectors of healthcare, working with the professional physicians organizations but particularly working in the safety net because they are such important providers of care for underserved patients.

So with that, I'll turn it over to my colleagues and we'll hear their responses.

Garth N. Graham: I want to start off by saying a couple of things, one, you can see that (unintelligible). The second is I want to congratulate Anne, Steve and the staff of the Commonwealth Fund for a very, very important report and I'll tell you why as I kind of go through where we are from the Department of Health and Human Services perspective understanding as we build this armamentarium around dealing with health disparities.

You know, my mom who used to always say something and I talk about my mom all the time so stop laughing Dr. Hughes.

She would say, you know, there are two kinds of people in this world, there is one group that does all of the work and another group that gets all of the credit. She said try always be in the first group because there's a competition there.

I found out much later that she actually got that from Indira Gandhi but it's very important around this work that we're dealing with health disparities.

Oh, what does that mean? Well, not to be repetitive, but Anne was talking a little bit about where we are in terms of health disparities of the nation. We've seen from the most recent National Healthcare Disparities Report that we have made some progress but not enough where any of us could be proud or any of us could be happy in terms of what we're going as a country.

One of the more importance of the many, many, many findings that we can talk about here is this issue around disparities and quality.

So what do I mean? One third of racial and ethnicity disparities and quality are actually getting larger and only 1/4 are getting smaller. So when we talk about various measures around quality and we talk about mixing and marrying

this conversation around quality and health disparities, understanding what is quality healthcare is very, very important.

I'm going to give you my last mother story.

So my mother always used to always do one particular strategy that would have all of her five kids up and out on Saturday morning. She'd say, "You know, if I tell you something you might forget, just so if I show you, you may remember." But then she'd say, "But if I involve you, then you'll understand." And that was her strategy for always getting us to do more and more work.

So as I was going through the study the last couple of days ago when Anna sent us a copy, I was kind of understanding a little bit more about this definition that was implied here around the uses of a medical home. And I was actually involving myself in terms of (unintelligible) perspective and my actual provider is a friend who graduated in medical school a couple of years ahead of me.

So I said, okay, I do have a regular source of care. So that's important I have, you know, a place that I can call, you know, I think I have a number that I can call. But I was thinking, do I have difficulty contacting this provider by phone? And so, even though he's a friend I kind of do because I want to see him after trying to catch him at church or at a basketball game or something where we can see each other that I was thinking about this issue about no - about the difficulty getting care or medical advise on weekends or evenings and then it kind of got even more troubling and then I start to think about whether his visits are well organized and running on time.

All I have to say is that we have all different kinds of challenges especially when we define quality of care and it's important for us to strive for the best

quality of care and we're not just talking about best quality of care for racial and ethnic minority population, we're talking about the best quality of care for all Americans.

Another important factor to me and then I'll get into some other points is when we have the disparities conversation, we're not talking just about African-American issues or Hispanic issues or Native American issues, we're talking about true American issues and where all Americans involved in this conversation together, both from the public sector and from the private sector as well.

So I'm hoping as we talk more about this concept of a medical home and how we use it in terms of dealing with health disparities, we talk about how we all can work together and that's why we want to applaud the Commonwealth Fund for their leadership in terms of continuing to highlight this issue around medical home.

Going off of definition because definitions are very important; I like the definition that was used here because like I said before, it really sets the bar high especially for some of us who now need to go and seek a medical home in terms of quality of care.

But one of the important things Anne was talking about earlier was the definition that came out of the American Academy of Pediatric many years ago. As Anne had pointed out, this group has been on the forefront in terms of this definition and dealing with issue around medical home.

So one of the things that they pointed out was aside from medical home being continuous and coordinated, the very last thing that they pointed out which is

very, very important is that it needs to be compassionate and culturally effective.

So what does that mean? Well, it means that if you put all of the various things aside that are important in terms of quality of care, we can't leave out this issue of cultural competency.

It's very, very important and actually this is one of the things that our office has done a tremendous amount of work on and I want to talk a little bit about it as well. But it's important that when we talk about quality of care that we don't leave out the issue of cultural competency and we actually put it at the forefront of the conversation.

I remember when I was at medical school we would learn about biochemistry, we would learn about everything else and then the last class that everybody would skip out in the afternoon was the class in terms of understanding patient care and patient interaction.

This issue of cultural competence we have to actually inject it at the forefront and not at the backend as we actually develop more and more on this definition around the medical home.

So Anne asked me to talk a little bit about some of the efforts within the Federal Government, some of the things that folks at HHS are doing but I also want to point out that aside from HHS, there are actually a lot of individuals at the state level who have been working on this concept of medical home or actually in the nation capital. (NBC) has been doing a lot of work, (NBC) has been at the forefront around developing a lot of local and community solutions; they're on medical homes as well.

But within the Department of Health and Human Services, we have all kinds of folks that's been working in this particular issue. We actually took this concept very seriously about a year and a half ago in my office where we were working with the National Center for Minority Health and Health Disparities; many of you are well aware of that center lead by a fellow by the name of Dr. Ruffin who puts a lot of effort in this issue around health disparities.

And we partnered with some folks in Louisiana to develop a medical home concept, a really very kind of integrated medical home concept and we're working with the Northwest Louisiana Biomedical Foundation. We put a couple of million dollars into developing this concept; they are on longitudinal care.

But not just longitudinal care and again going back to definition of quality but also making sure that this care was not only coordinated but actually had all of the various components around quality of care, that included the usage of electronic health record, that also included community consultation and the ways in which the community would be in the forefront, in the middle, and at the backend of all the decisions that were being made as well.

And also looking at how there can be various partnerships going from the local level to the state level and all the way up.

So as we kind of look at various models around developing a medical home, this is one of the efforts that we have taken from the Office of Minority Health perspective.

Anne was pointing on some of the work that HRSA has done in particular looking at community health centers. Aside from community health centers looking at the 330 Health Center Program, we also see where the medical

home concept has been developed for especially looking at Migrant Health Centers, Health Care for the Homeless Health Centers and Public Housing and Primary Health Care Centers that actually are located in housing complexes.

Why do I say this? Well, location of health centers is important, right? So if we have healthcare access points that are located away from the community, the quality of care could be high but it could be also be challenging to be able to actually get to that particular location and then you're going to hear from some people who are at the ground level doing that particular work and they're going to talk to you about how all the different factors around quality of care are important.

Anne pointed out this issue around the care and the population that health centers reach. Well, you know, actually when I first came to the United States, one of the first places that I got my healthcare was at a health center. That's because health centers for the most part, there are many health centers if not all that provide services to folks who don't have a lot of money and we fell into that category initially when we first came here.

So health centers to me - I ended working up for a little while at a health center and I've always had this love relationship, not love-hate, but it's really the love relationship with health centers because I know that they do reach the people.

So Anne was pointing out that up to 64% of health center populations are actually made of racial and ethnic minority population. That's a very, very, very large percentage. The Hispanic population, about 36% of the health center population is made up of the Latino population, about 23% of that is African-American.

So what does that mean? It means as we've been developing as a department, the health center program, we've also been integrating this conversation around quality of care in a variety of different ways. One is the health center collaborative which many of you are very well aware of. And working with the institute for healthcare improvement at a number of other individuals, they've actually been developing disease models and disease management models that are looking at some of the things that Anne was talking about in terms of performance improvement in terms of actually having models in place that get to that issue around quality of care.

Most recently, HRSA established the Office of Quality which has been developing more of these measures that can be integrated not just into the health center collaborative activities, but into all of the various facets of healthcare delivery that HRSA provides and again going back to the populations that they touched in particular.

One other thing I wanted to talk to about - talk to you all about in terms of understanding various aspects of the medical home within the Federal Government is also looking at Title 5 of the Maternal and Child Health Program. This is the Block Grant Program. One of the things that they do do is establish medical home for all children with especial healthcare needs.

At the forefront of these conversations and a forefront of some of the examples I was giving from the HRSA perspective and things that we're working on from the Office of Minority Health perspective is two things; its quality and its cultural sensitivity.

I was giving you the example of my friend, even not friends so much anymore, who was helping me out with my medical account. I'm going to put it that way now that I understand more. And it's important for people to have

healthcare providers that they can relate to. It may not be their best friend, their uncle, their aunt. It should not be their uncle, but it may not be as one of the - somebody along that line.

But it should at least be somebody that they can relate to at a very personal level because healthcare is very, very personal. That's one of the things that motivated me to go into this particular profession.

We have been working with the National Association of Public Hospitals and Institute for Healthcare Improvement. And we've been glad to have Anne be a part of our effort around developing some of those activities that can help promote quality within that healthcare setting and we're going to be hopefully releasing something that we call a change package working with (IHI), (NAPH), and a number of other expert individuals that will help guide hospital systems especially public hospital systems about what are some of the things that they can implement to help improve quality again with a bend towards cultural sensitive material.

I have a number of other points I could make here, but some folks have been educating me on the importance of speaking to eight minutes. But one of the things I wanted to again talk and thank you Anne again is understanding more around why cultural competence is so important. I think I gave you a number of examples. I want to tell you a little bit about some of the tools that we've been developing really just within the last couple of years around that.

Many, many years ago or a couple of years ago, I should say, we released the class standards as a way of at least providing some guidance around what folks should be doing to provide a cultural and linguistically appropriate care. We have actually been developing more and more tools that folks can use along those lines.

So most recently, we developed some cultural competency training modules for physicians. We developed some cultural competency training modules for nurses. My mother is really happy to see that because she is a nurse.

But really, you know, activities that I directed at the healthcare provider community and the other thing that we did was we develop a Web-based healthcare language implementation tool that can assist healthcare organizations in planning, implementing, and (evaluating) language access services to minority population.

Apparently, my time is up, but I'll try to make some of these other points during the Q&A period. Suffice to say that there are a lot of individuals including folks in the Federal Government, I can't say it's all or (unintelligible), but I do want you to know that this is something that it is important for us.

The number of individuals at the state level, I talked to you a little bit about what's going on here in D.C. and all different states and all different kinds of activities and there are folks all around the country that are buying into this concept around medical home.

So as we bind to this concept, let's make sure that the models and the definition and the criteria that we use are going to be beneficial not just for ourselves, but for the communities that we care so deeply about.

So that's it.

Okay.

Dora Hughes: Good afternoon. I want to start by thanking the Commonwealth Fund as well for inviting me to participate in the panel today. I will have to say as a former Commonwealth Fund employee, I was slightly bemused when Dr. Beal took great pains to remind me that that Commonwealth Fund was independent and non-partisan foundation.

But her point was well taken and I promise that any use of the terms majority or minority today will just relate to populations in the US. There'll be no (unintelligible) mentioned to campaign platforms, no speaking about the audacity of hope. My comments today will be independent and non-partisan.

But I'm serious and in fact sincere and frankly, it's very easy to do that because the issues that were described in the report of findings about medical homes is one that has really captured the attention of not just my boss, but members on both sides of the (house) and both houses of the Congress and I do expect to see some continued momentum on promoting this issue at the - at Federal level; actually the session in Congress.

As many have noted, the concept of medical homes is not a new one. A number of esteemed physicians, as well as primary groups, many are represented here today including the American Academy of Pediatrics, the American Association of Family Practitioners, the American College of Physicians, they have all developed and promoted the implementation of the medical home model for many years at this point working jointly to develop the principles.

In addition, as my colleagues in the executive branch have reminded me, they too have already implemented supporting the implementation of these programs and as well as we see a lot of activity at the state level.

Yet despite the effectiveness of these interventions and the power of the lobby of the primary provider groups, this concept, the medical home model, really has not gotten attention that it deserves by the Congress nor it had much traction until more recent years or maybe this year to be very honest.

I think this fact has to do little with concerns or questions about the effectiveness of the medical care home model and more to do frankly and I might be a bit dated, but the historic reticence on the part of the Congress to truly tackle the health reforms that are needed to meaningfully address our problems with healthcare quality that we know exists in this nation.

Yet I think it's fair to say that Congress is now very much onboard and reports such as the one that was just released today are helping to increase our education and awareness about not just the problems, but about interventions that work and they're also helping to reinforce some of the lessons from the earlier quality reports such as those released by the (IOM), (unintelligible) quality caused them unequal treatment and so forth.

But it's not the quality issues in and of themselves that have really moved the Congress. It is the recognition that poor healthcare quality costs money. Preventable emergency room visits, hospitalizations, duplication of the tests, lack of coordination of care, all of these cost a lot of money and you can measure this poor healthcare quality indicators, you can measure it, but the human cost, as we all know, over a hundred thousand deaths of Americans every year just from (medical areas) alone, as well as financial cost using estimates from the Commonwealth Fund, there are estimates between \$50 million and \$100 billion are wasted every year because of inefficient healthcare quality.

And the current financial climate that the Congress is desperately trying to find ways to contain cost and never mind if I mentioned tax cost, but we won't today. Obviously, improving healthcare quality is one way that we are really tackling.

As many of you know, in the Medicare Modernization Act, the Deficit Reduction Act, we authorize a number of quality initiatives demonstration projects, whether it be chronic disease, coordinating care, hospital measurement reporting, all of these are well underway. Some of them are starting to wind down.

In 2006, the Tax Relief and Healthcare Act actually included language that authorized the medical home demo. More recently, a number of other medical home legislative proposals have been introduced. I'm proud to say Senator Durbin has recently introduced a very thoughtful, well-crafted proposal as part of his SCHIP reauthorization proposal.

And we do expect to see his language which would create a medical care - medical home model and the SCHIP and Medicaid programs. We do expect to see some of that language to be included in the final SCHIP reauthorization. As many of you know, we expected to see the SCHIP reauthorization mark up and finance committee, but that is enforcing is going to be delayed.

In addition to legislation that specifically mentioned the medical home model, we're also deliberating a number of bills that touched on the key components. As I was checking my Blackberry, my fellow let me know that the Health IT Bill has been specifically marked up and in the Health IT Bill, the (wires) for Health Care Quality Act, in one grant program, entities that are implementing at the advanced medical home model which they decided not to define which I

think reinforces some of Anne's points earlier that they will get a preference for funding.

And then also and largely, frankly, because of Senator Obama's efforts, the Health IT Bill does have some emphasis on supporting the efforts of providers, institutions such as community health centers that arguably care for the most challenging of our patient population.

In addition to the Health IT Bill, we have introduced the Minority Health Improvement and Health Disparity Elimination Act a couple of months ago led by Senator Kennedy. The bill has a heavy emphasis on quality both in looking at, for example, supporting consortiums of institutions, dedicates improving quality by formerly authorizing the disparity collaborative that Dr. Graham mentioned.

By increasing (unintelligible), that helped data collection and reporting, we expect that while we will attempt to mark up that bill possibly as early as July and that will represent truly a good step forward.

In the final (unintelligible), I'll just mention for the sake of time, the Community Health Center Reauthorization Act to maybe marked up in July as well and that would provide additional opportunities to address some of the issues raised in the report particularly how to increase the capacity of, again, of some (unintelligible) to increase healthcare quality for, again, a very challenging populations that they serve.

Senator Obama is the co-sponsor of all the bills that I've mentioned and we will join with our colleagues on community, really required to get all of these important bills passed the Senate and the House and enact it into law.

But even with these legislative efforts and as promising as they may be and certainly I am truly excited about all of them, I think the most challenging barrier and I'm sure all of you will agree is the full implementation really, really is to reimbursement.

To really move forward, this Federal Government is going to have to step up to the plate in a major way to make sure we're aligning funding, reimbursement with healthcare quality.

Right now, we do not reimburse for coordinating and integrating care. We do not reimburse physicians to conduct those telephone consultations or to answer emails, to see patients in their off hours on the weekends. We don't pay for chronic disease management, we don't pay for health IT implementation to help off of these costs, we don't adequately reimburse primary care providers and that's why we're facing the crisis that we are with more and more specialists and fewer and fewer generalists in every graduating medical school class.

The bottom line is we are continuing to pay providers for the volume of services and the type of services they are providing and not necessarily for healthcare quality in good health outcomes and if you continue to do what we always do, we will get what we always get.

Aligning financial in centers of quality is going take two leadership, possibly new leadership -- that's my only quote -- from the executive - I'm sorry. It's in my blood, you know, four years on the health, it changes you. You know, funding executive and the legislative branch.

It's also going to take courage and commitment on behalf of the medical community to really reform medical practice. Again, we're already seeing examples across all of the primary care provider groups.

So we're also seeing news on the specialty groups to see as examples obviously being anesthesiologists, the cardiologists, the surgeons who are all really starting to tackle these reforms and we're also going to need to see a continued call to arms from the patients and advocates themselves.

I do think we're going to see this happen. Our fragile healthcare system, as we all know, is in the brink of disaster. I think we're at a pivotal point in time because on the same page we have employers and providers and patients and unions and payers and insurers. It's really all starting to come together and I do think we will start to see forward movement for health reform.

(Unintelligible), I just want you to know when I was preparing for this speech, I was looking across the number of different bills that I made mention that I was struck by an essay that the American College of Physicians had posted on their Web site. It was the writings of a Dr. (Francis Peabody), an esteemed physician who as early as 1927 was (unintelligible) the idea of a patient center provider coordinated care for the patient.

And in his essay, he writes and I'm going to read directly, that doctors should see patients as individuals not cases or examples of diseases and we should engage deeply with our patients to make home visits, to see the sorrows of severe illness, the hardships and resource of the family and the circumstances of our patient lives.

His writings are describing, to me in my mind, the core of the medical home concept and his words still ring true today. I'm excited to see the progress

being made with moving from just the theory of the concept of medical home to widespread implementation. And again, I want to thank you for your time and including on the panel. I look forward to working with all of you to success.

Anna Maria Izquierdo: Hello. My name is Anna Maria Izquierdo. I'm the Medical Director of Spanish Catholic Center of Catholic Community Services and I think I was brought in to put a face from the provider side of the equation. We are the ones that either give a quality of care that sucks or try to improve it.

So hopefully I'll show today that we are really making an earnest effort to improve and the importance of actually having a medical home.

Just so that you know where I'm coming from, the Archdiocese of Washington funded the Spanish Catholic Center in 1967 to help essentially new immigrants to the country (unintelligible), to become Americans. And such mission we had language services, immigration services, social services.

But we soon realized that one of the big problems that immigrants face was healthcare and how difficult it is to access healthcare in this country and once you access, to get - stay there, get good care and understand what's going on even if you speak English may I say. So we created the health services which have a dental component and a medical component and we serve adults and pediatrics.

Recently, in July 2004, the archdiocese decided to merge four of his agencies. So Spanish Catholic Center had merged with (mental health) which deals with the component of mental health with Lt. Joseph P. Kennedy Institute who - they do disabilities and with catholic charities which I don't think I need to explain what catholic charities do.

We also have been part of the D.C. Primary Care Association from almost the very beginning or closer. And we are a very interested part in the medical homes project of the DCPCA and actually, once we're done, if anyone wants details on that, Sharon Baskerville who is the Executive Director here, I'm sure she'll be happy to answer any questions you have.

But before I go into this, I wanted to tell you the story of a patient because I think, you know, patients are what get us going what makes - sorry. Medical home, (unintelligible) what actually get us going and make sure that we go to work everyday and do what we need to do.

So this man, a 50 something year old Cuban guy, came to the clinic. He had come a couple of times. He was homeless. So he didn't come very often. So he came on the very beginning of me being there and he says, "Doctor, what I want from you is for you to keep me out of the hospital." I'm like, "Okay. Tell me about it."

The first thing the guy tells me is like, "I have this chest pain. I have had a lot of heart attacks and I'm in the hospital every other week and I'm tired because they poke me, they poke me, they poke me. They put things in all my holes and I don't understand anything. They send me home and one week later, I'm back." So I'm like, "Okay. Well, let's talk about it."

So I sort of figured out what his medical problems actually were and I told him, "Look, in order to keep you out of the hospital, there are two things. You need to come when I ask you to come and we'll debate what needs to happen. But you need to do it once we come to an agreement."

"Okay. I just want to be out of the hospital."

"Okay."

So I started seeing him every week and for the first time, he was not in the hospital for six weeks. At six weeks, he had a severe chest pain. So we needed to send him to make sure he was not having another heart attack. But then he didn't go to the hospital in additional three months and after that, he had an AICD which was one of those defibrillators placed and he didn't go to the hospital in one year.

So the concept of medical home and what it means, I think in terms of research, it may have multiple definitions, but for this man, medical home was somewhere he could go and not have to go to the hospital every time he had a concern or he had chest pain or he had anything.

Actually, he started - we really love him. He became family. He was homeless once. His shelter said, "It's time for you to go somewhere." Wherever we choose to go, he'll come. He'll help us clean. When we needed to go to the council and argue about something, he would be there. "Yeah, you need to" - "They're my daughters. You go and help them."

So he really became part of the family. Unfortunately, about a year ago, he developed (unintelligible) and we found out that he had developed a lung cancer in addition to all his heart problems. So continued to come and see me everyday religiously. I actually only saw him once a month. I just visit, but I saw him everyday. "Hey, are you doing good?" "Yes. I'm coping a little bit more." "Okay, no problem."

So eventually, what ended up happening is he ended up in palliative care in a hospice and one day he comes because he used to come also from the hospital.

And he said, "Doctor, they're asking me a Power of Attorney." I'm like, "Okay. So who do you want your Power of Attorney to be?" And he said, "You". I'm like, "I cannot be your Power of Attorney. I'm your doctor." He said, "Okay. What's this Power of Attorney business?" "Like someone that will make the health decisions for you." He's like, "You."

So we talked for a while and after was adamant that I needed to be his Power of Attorney. So I became his Power of Attorney until the day he died.

So for me, that is a concept of a medical home. A place where you go and whether - as a disclosure, I have to say, we have some evening hours and some weekend hours, but we don't have 24/7 coverage. Just as a disclosure for the research definition.

But for me, that's what a medical home is, a place where you can go where people know you. My case manager used to go to visit him in the hospice and bring him tobacco and I'm like - he stopped smoking for a while once he was diagnosed with a cancer." He's like, "Doctor, do you mind if I start smoking again" "Okay, go ahead."

So that is a concept of medical home. From a practical point of view, what we do at Spanish Catholic Center to try to really fulfill all the potential of what a medical home can be is we really truly accept patients that we can see on a continuous basis. The volume thing, we are very careful not taking more patients that we can't actually offer good care for.

Our walking policy is we truly encourage our patients to set up appointments and to follow them. When you're diabetic and you're diagnosed, we tell you, "Okay. You're going to have to come and see us four times a year, get labs four times a year and come every appointment. Don't skip them."

And in our community, we see 95% Latinos and they work and get paid for the work they do. So coming to the doctor is a hard thing to do for them. And when there's an event of acute symptoms, they walk in and we will see them and with hardships sometimes.

What I was saying, the chronic disease follow up, we are very - you need to come and I think that we try to do is we have a dispensary and a lab so that people don't have to go 30 places. When you come, we'll draw the blood, we'll the test, you'll get the medicine and you'll go home in one visit. A long one, mind you, but one visit nonetheless.

And then we have the in-house services, we also have education services, we have screening programs and we are recently working very hard on implementing quality improvement initiatives which I'm going to show you very briefly some results because I think it is important. What makes people in the community health centers go to work everyday are the patients.

But what we need to do is to work not only on that interaction, on that how are you doing today that actually gets you to sleep very well at night, but also at how do we do to improve the actual care and that's very important to us. How do we do? We self-collaborated actually.

I see some faces with the arch to do some improvement in the self-management goals and our Diabetes Management Program, this (slide) is a little bit busy but let me tell you. The green peas is a matter of diabetes quality care which is the number of times you get hemoglobin A1c which is a measure of how your sugar is controlled over a period of time, usually around three months and the squares, the top line of the square is the Medicare number, that bottom line of the square is Medic Aid and I forgot to tell you,

but 98% of our patients are uninsured and the rest have either D.C. Alliance or PACT Program from Maryland.

So in terms of the amount of times that we get a yearly hemoglobin A1c, we do quite well above the national numbers for Medicare and Medicaid. The red line are the people that are not doing so good.

So the red line goes with the square and these are the numbers that have an hemoglobin above 9 and that's bad. It should be under 7 and actually, some recommendations now say towards 6.

So we have managed through some of our initiatives to decrease the number of people that have a poor control of their diabetes. Also, the lower line here is the Medicare and the upper line is the Medicaid.

So we have managed to improve this above the standards of Medicare and, unfortunately, I didn't have data to look at the good control patients to compare but essentially, I just wanted to show you that slowly, we have been improving the percent of patients that are under good control.

Another thing that we are doing is the advantage and actually, there are some advantages of having no insured patient is that you have a white canvass and can do whatever you think like, "Oh, I'm waking up. I'm going to do prevention." There you go. There's no worry about reimbursement. There's no worry about all these things.

So we decided that we would take a good look at how we do preventive services. So the blue line is the client patient and this is some of the Medicare numbers and the red square is 100%.

So we are close to 100% in terms of paps, mammograms, (FO), (BGs) and cholesterol and - sorry, close to Medicare. But we said, "Hey, Medicare is good number, but we need one better."

So we established a preventorium. Now, preventorium is a clinic where people come and get all the US preventive taskforce recommendations for preventive care in one visit which is really important to our patients except for the mammogram. So this is how we have improved. The blue line again is how we did in the clinic in general and the orange line is our preventorium.

So my point is that a medical home improves the quality of service that you receive and whether you're insured or not, there are ways that we can look at how we deliver care to improve and essentially it needs to be in a place where the patient trusts you and will come back and receive all the services.

Thank you.

Steve Schoenbaum: Thank you all very, very much. I'd like to throw the floor open for questions. Yes?

Conference Coordinator: If you'd like to ask a question, please press the star and then the 1 on your touchtone phone. You can withdraw your question from the queue at anytime by pressing the pound key.

Woman: (Unintelligible) the campaign platform, but I think very broadly just from the activity that we're already seeing in the Congress which is generally in lock steps with what we're seeing in all of the candidates' health platforms, we would expect to see. I do think that it's fair to say that moving forward that we will, both increasing the reimbursement, as well as increasing the other

resources whether it be technical assistance and so forth and to a more widely extent implementation of the advanced medical home.

Man: (Khalid Karim) with (unintelligible) (McDonald's) office. Question has to do with we're looking at the King/Drew Medical Center facing closing similar to what happened here with the D.C. hospitals and similar to what's happened at the Prince George's County Medical Center and it would seem to me that these institutions would be your ideal medical homes because they are 24/7 operation.

In the DHS and other, you know, and is their support on the (hill) for, you know, perhaps, you know, putting more money into the utilization of the existing medical facilities that are providing particularly primary care for the indigent population as opposed to seeing these institutions, you know, face closure because of a lack of the path of support.

Man: (Unintelligible). I think the challenges that you're seeing all in California are huge and tremendous. We have been looking especially from the (ASTHO) minority health perspective because the health facilities there is linked to one of the nation's I would say premiere medical schools with the Drew Medical School and some of the activities there and we continue to support Drew Medical School especially in terms of funding for faculty development and some of those activities.

But I do see that we - that we're experiencing with the healthcare facilities that you're talking about is this balance between protection of the population in terms of the quality of care that is provided as well as making sure that we are able to have locations or access points or (unintelligible) access care.

And it has been a challenge like I said one of the things that would especially from the (ASTHO) minority health perspective is to make sure that we at least continue to assist the Drew Medical School in particular in terms of the training that's provided in terms of some of the faculty development, some of the various activities there and we have funded it and probably might continue to fund a lot of those programs there.

But I think what you're describing in terms of the other end of the spectrum is really that balance between I would say kind of population protection in terms of protecting the populations that are located there in terms of quality of care, as well as making sure that there are various access points in terms of access care. I don't know if, doctor, if you want to talk about it from the congressional end.

Woman: I'll start by saying we're obviously seeing similar problems with Cook County in Illinois and I think that given the number of institutions involved is just a very clear sign of the increasing problems at the safety net institutions whether it'd be large public hospitals or community health centers they're facing when they are trying to care for the most challenging of the patient populations and just remain horribly underresourced.

And in addition to the funding issue, then obviously we are increasing trying to preserve Medicaid funding and trying to prevent cuts from the Medicare funding, trying to get as much money as we can for the - do the SCHIP reauthorization.

The setting of funding difficulty is a sign enough to minimize that just even to past legislation has been difficult in the Senate. Volume of populations are surprisingly not historically popular on population or may not that surprising and despite whether we focus on (role) or minority, how are we defined.

And so my experience is with the Health IT Legislation apparently maybe more cognizant of the difficulties that we will have even passing the minority health and the health disparities that is by partisan and also health community bill. But you know, at the same I don't think it's difficult if there's anything new and I think as long you have community individuals who remain in the fight, that we just have to continue to push forward and hopefully into all of our public institutions crumbling to the ground before we're able to mobilize and be effective in our efforts.

Man: Of course, I have several people have noted the questions of (unintelligible).

Sharon Baskerville: My name is Sharon Baskerville, Executive Director of the DC Primary Care Association.

I'm interested to hear reference always around the struggling public hospitals and hospitals being a 24/7 kind of model of care. But the issue of the disparity that I didn't notice in the Commonwealth report was the disparity in reimbursement which was touched on between primary care and end of life care and inpatient care.

And in the District of Columbia I can give you an example of the city that's very progressive in its coverage, is very progressive in its determination to provide healthcare.

The Medicaid pays \$45 of visits for primary care visits and the DC Alliance which is a locally funded 153 million funded to cover everyone of that 200% of poverty; very progressive. Pays \$65 a visit for a primary care visit.

Now the expectation of quality improvements, of facilities, of all the things that are needed, when the average cost of care, forget wrap around services, cultural competent, all those other things is \$151.

So, in some ways as long as we are hand strong by a mentality that's institutionalized, the good healthcare happens in large institutions instead of small places. I'm not under the illusion that we don't have to have reimbursement. But there is some freedom and not being driven by what is currently a broken healthcare system that does not emphasize what we heard here today. I can tell you that medical homes DC in the District of Columbia was medical homes before medical homes was cool.

And I hope that people pay attention to what's really needed to shift, the thought process to change thing.

Man: Correct.

Man: Is there supply of people to staff these medical homes is the fact that medical home is more of a concept. It isn't necessarily a place and so in fact confounded with both supply and reimbursement is how do you deal with new services that have not traditionally been in fee for service reimbursement and so on.

So, we're not going to be able to get into all of those but frankly once you get into the idea that medical homes are important, then it opens up a whole new area I think of policy thinking as to how you could reframe this discussion and make progress.

I have a question back here.

(Bob Hall): I'm (Bob Hall) with the American Academy of Pediatrics.

Thanks so much for everybody's focus on pediatricians; looking at this such a long time back.

I'm wondering as the report of the survey was done we would of course define some of the people who reported as children so pediatricians do see a lot of people who are over 18. And I'm wondering what other sort of followup in the pediatric population might be contemplated by the Commonwealth Fund.

Man: Your say in that?

Man: We have a program that's entirely devoted to the pediatric population and it's about child development and prevention and that program has been trying to promote a new model of care for young children that would be more developmentally based. In fact a lot of the things that are involved with it are very much related to the medical home concept.

And one of our grantees, a person named (David Bergman), a noted pediatrician at Stanford, has been working on new models of pediatric care that are very much consonant with this notion of medical home.

Yes and we need to get through a microphone, yeah, really yeah.

(Den Hawkins): Hi. Are we on?

(Den Hawkins), Community Health Centers. I want to say two things, one quick thing and then a question. In particular I think what is so important about the study, at the end of report is that really and powerful ways for the first time, it makes the argument that achieving equity in healthcare and

improving overall quality and outcomes is about insurance to be sure, but it's about so much more. It's about also having a committed regular source of care.

Man: Yeah.

(Dan Hawkins): And as you can see, health centers and I think there one thing with other community clinics are struggling to try to be those medical homes and healthcare homes, they are today for 16 million American.

I want to raise the question and it's more for Anne, Steve than yourself but for all of you, Dr. Graham mentioned the importance of culturally appropriate care. Dr. Izquierdo mentioned the importance of a couple of other features that are a traditional part of the medical home definition.

One is continuity of care across changes in health insurance coverage, in health status, et cetera. I think that's very important. And the other is the integration and coordination or ease of management of care across both medical but also other health services, oral health, mental health. We find that at health centers you can't just do medical care. If you do, you're in a wrong box, way to small.

And secondly, to deal with other - the other social environmental economic determinants of health - population health, you've got to be able to do. So the question becomes okay, you chose these features of a medical home, not so much why didn't you choose the others, but at some point, are you going to ask the question, what do we really want in a medical home or healthcare home across those other features that are equally important in terms of determining whether someone has a committed sponsor to use a term that's critically important.

Anne Beal: The focus of this particular report really is on this concept of the medical home, but one other things that we wanted to do after we saw the preliminary result was to really look deeper into these issues of the quality of care particularly in the safety net.

And so one of the things that are not included in this particular survey or this particular report are questions about trust and adherence and I feel treated with respect and those where the questions which we're currently hypothesizing, would be particularly strength of facing that providers.

And so part of what we want to do then is a follow-up series of analysis to look just at those kinds of questions with the safety net. What is that the patients are telling us that provided do and don't do for them because the way I tend to think about of the quality of care, what might define is a physician which is doing the right thing at the right time.

But we also think about it in terms of what my grandmother might say in terms of if I was treated with respect, they got all my questions answered and so, therefore, I think that these providers being a high-quality provider. So that's the follow on with more to come.

Man: The other thing I think is that, you know, was early on alluded to that one need standards for medical homes. We have yet another program at the fund that's called Patient Centered Primary Care.

And one of the earliest grants from that program was the NCQA, the National Committee for Quality Assurance, here in Washington which has been working on something called Physician Practice Connections and is trying to define what might be some of the elements going to medical home. And I

think making sure that those are really very comprehensive as important but also trying to help those providers who are trying to offer medical home services, get recognized as having met certain standards, having met them being able to feed into reimbursement policies or other kinds of reward I think will be important steps down the line.

(Dan Hawkins): Kind of get the one question answered.

Man: Yeah.

I think you're bringing everybody a good point. So what's your name again?

(Dan Hawkins): (Dan Hawkins).

Man: (Dan), I think you bring up a very good point, so I can call you, (Dan).

Is the most positive nature of...

Man: As long he doesn't have to call you doctor.

Man: No, I think - Garth, (Dan), we're talking here.

But so, I think you bring one of the very important point I think we have to make here which is that the issue on healthcare disparity - actually the issue on healthcare is not simple, it may get even more complicated when we really look at this concept thereon effective solution thereon health disparity.

We're talking about one particular solution today. It's a very important solution, it's not end all be all. And I think when we really kind of effectively as a nation and when I say as a nation commit to dealing with health

disparities. I'm not talking about just the hill perspective. I'm not just talking about not just a Federal Government, I'm talking through as a nation going all the way to the individuals and individual person understanding what they need to do to protect their own health and then talking about provider responsibility and health providers interact with patients.

So, I think one of the things that I was going to kind of pull out of your question, and then I want us to really to leave here thinking about today is this discontinue our responsibility when we think about health disparity, when we talk about healthcare and that it doesn't just end with the folks who are on the hill or folks who are running for president or that kind of thing. It really does go across the full spectrum of folks that need to be involved in this particular set of activity and be committed.

Man: I have several others but I think one very (unintelligible) here, I have another here - we're going to have (unintelligible)...

Nicole Lang: Hi.

Man: ...but we'll stay around if we have to.

Man: Oh.

((Crosstalk))

Man: All right.

Nicole Lang: My name is Dr. Nicole Lang and I'm a pediatrician in Washington DC. And I actually have a medical home that I have created for my patients. I take

primarily private insurance but I also indifferent from other private practices in the sense that I do take Medicaid patients.

And I do have issues obviously with reimbursement but I'm not letting that deter me from treating patients that can afford me and patient that cannot. And my sense are also has a wellness component in the sense that we treat the whole (unintelligible).

The mission is to provide comprehensive care from in the physical, mental, spiritual, social, emotional developmental perspectives. And so my patients come and have services like patient consultant, we have literacy programs, we have a nutritionist, we have social workers and so we're providing on a small context in a private practice setting a medical home.

And so what is possible for practitioners to do it and I know it's not just in theory perhaps that I'm here to tell you that it actually is a reality that I'm trying to create a medical home in the Washington DC area and have a multi-cultural patient base. And because I know pediatric was addressed if I just want to follow up and let you all know that.

Woman: And I'm actually glad Dr. Lang spoke up. She and I actually spoken on the phone because...

Nicole Lang: Hi.

Woman: ...(unintelligible).

Because actually one of the questions that I received when we first start to talk about this concept is could this actually be done, is this a reality? And so one of the things that we included in the packet that you received today is actually

provided to have identified themselves as really providing medical home based care.

And so what we wanted was representation from community health centers, we want providers on the East Coast, providers on the West Coast, providers in urban setting, providers in rural setting, Dr. Lang represents provider in private practice.

So this is not just something that one does when you're your part of a larger system but for anyone who is interested and actually following up and speaking to individual providers that really understand at the ground level what does it mean to be a medical home provider, we did provide that information in your packet.

(Rod Taylor): My name is (Rod Taylor) from the Maryland Healthcare Commission.

I think first of all, I like to thank and acknowledge the Commonwealth for pointing out what I still think is an underrecognized situation in terms of status for health system across the country.

But it is basically in a turmoil and if are not quickly involved in redirecting our resources toward a system of care that we can all feel comfortable with, I think we're going to see the continued demise of institutions, so it won't be just DC and Prince Georgia's County and Illinois, and the rest of us. I mean to the extent that we keep redirecting our primary care into our hospitals, it's just going to accelerate the demise of the system.

I did also want to acknowledge in terms of Dr. Hughes, you've been very active particularly lately in the number of different forums where you've talked about volume of populations particular in the area of healthcare, -

disparities in healthcare as it relates to women and heart disease and heart attacks and heart failure. How do you see the issue of medical homes as it relates to that being something that's going to contribute those issues?

Dora Hughes: The many aspects of the medical home is one just - the heavy emphasis on quality measurement, quality reporting and those at the provider level as well as the larger institution level and so that is an area that we have focus on in the minority health bill, that is the area that focus on health IT bill.

I do think that based on some of (unintelligible) - I mean we found some report that certainly institutions that have medical homes, it seems to be a rising tide, (list all both) or whatever, it's the same, I might be not planning it directly.

But - so everyone does better when there is a medical home but our expectations are that to the extent that they can kind of focus on certain populations that are more particular likely to be effective by disparities that those groups will also do better as well.

Man: Let's have one last formal question and then we'll - some of us at least can stick around I think ahead of others.

Beverly Coleman-Miller: My name is Dr. Beverly Coleman-Miller.

And I noticed as we looked at the graph that there's an awful lot of responsibility that the patient has like they have to have an address. They have to have money for sphygmomanometer to take their blood pressure at home. They have to have some place you can send the prevention that is some information. They have to have a lot of stuff.

And I wonder whether the medical homes concept is building in that some homes will work as well as others because homeless people are in that particular area and don't have the ability to respond.

Woman: I would say conceptually yes, I mean I spent the early part of my career actually being a healthcare provider for homeless families and we were a medical unit in front of the homeless shelters doing room visits when necessary. You have to go where the people are and what we wanted to do is be the medical home for homeless children living in shelters throughout New York City.

So, I think part of all of the things that you raised are actually critically important and what we're seeing is no matter where people came from, the medical homes were able to meet their needs so whether with financial, relocation or hours or whatever, they were to meet to the needs.

Man: Dr. Izquierdo.

Anna Maria Izquierdo-Porrera: I think one of the things that I made a joke about which is the advantage of having all uninsured is that you have a white canvass. The disadvantage is that you really need to be very creative in the way that you approach these issues.

We have - our population, the Latino population, is very mobile. They're not actually in homeless shelters but they rent a room in someone's home for a week and then move somewhere else.

So, there are plenty of challenges and, you know, we would never think about sending our reminders, but what we do is we make sure that the time they

come to have their blood pressure checked, we give them the appointments for their pap or their PSA or their whatever followup.

So, I think we need to be flexible in the way that we look at a medical home and the way that we're going to provide those services because it's true, if you, you know, if you go and buy a sphygmomanometer and then buy this like \$160 bills a month, you know, you're not going to be able to get the outcomes, but there's creative ways of doing things.

Steve Schoenbaum: Thank you very much.

I'd like to thank all of the panelists. I'd like to thank Anne Beal and Michelle Doty from the Commonwealth Fund and all of our other staff who are here for this report and thank all of you for coming.

Thanks very, very much.

Operator, please?

Operator?

Conference Coordinator: That concludes today's teleconference. You may disconnect at any time.

Thank you and have a great day.

END