



# **Transforming and Strengthening Primary Care Through a Team-Based Approach**

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# Why is The Commonwealth Fund Investing in Ways to Strengthen Primary Care?

**Patients do not receive timely, efficient care**

- **Poor access**: 71 percent of U.S. adults have difficulty getting timely access to care
- **Poor coordination**: 47 percent of U.S. adults report failures in care coordination
- **Inefficient system**: 54 percent of U.S. adults experience wasteful and poorly organized care
- **Low confidence**: Only 35 percent of U.S. adults are “very confident” they will receive quality and safe care



# **Why is The Commonwealth Fund Investing in Ways to Transform Primary Care?**

**Primary Care is critical to achieve high performance:**

- **Countries/communities with strong foundations of primary care associated with better quality, lower cost, greater equity**
- **Medical homes is a promising and viable strategy to strengthen primary care**
- **Early work indicated that medical homes can reduce disparities (Beal et al, 2007)**
- **Early results from medical home pilots show that quality improves, efficiency increases (Grumbach, 2010)**



## The Commonwealth Fund's Work Focuses on Three Main Areas

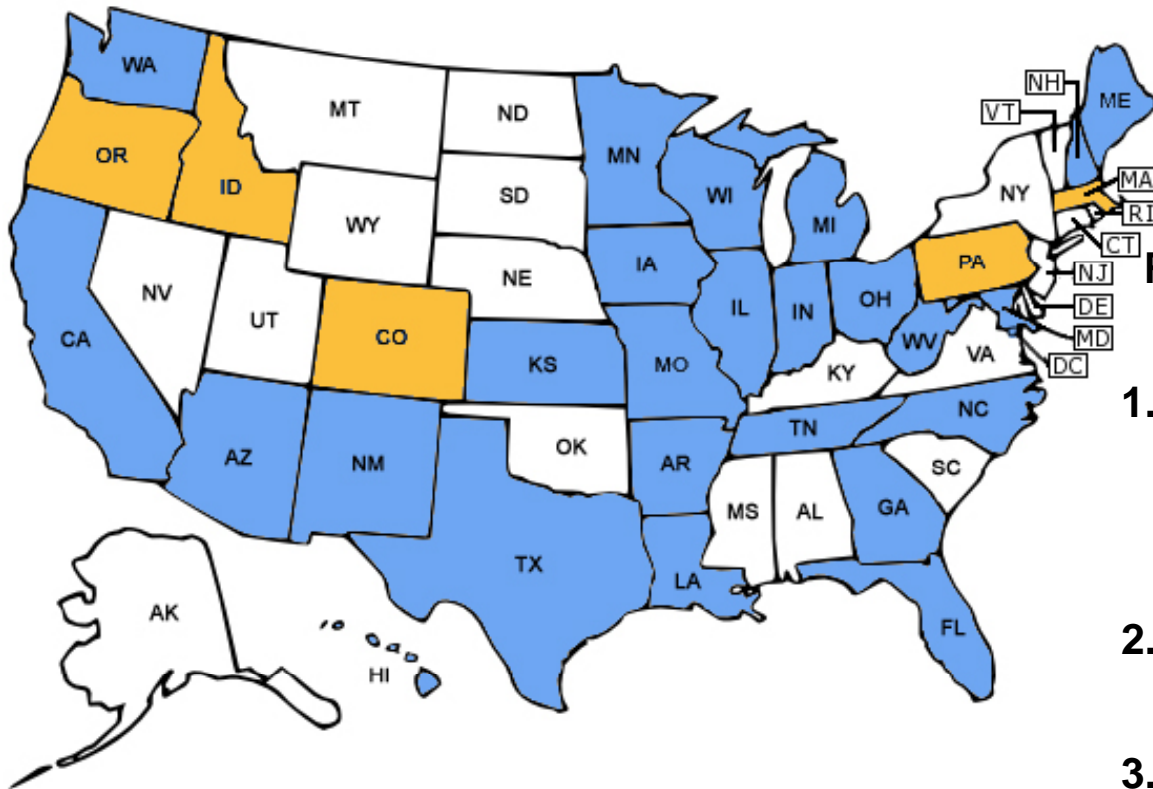
1. **Testing the model in safety net:** National demonstration with 65 Community health centers in 5 states
2. **Building the evidence base:** Supporting 9-10 evaluations of medical home demonstrations to assess impact on quality, cost/utilization, patient experience, clinician/staff experience, disparities
3. **Promoting and facilitating policy change:**
  - Support research to make measures more patient-centered
  - Work with state Medicaid and Federal agencies
  - Identify payment options



# Safety Net Medical Home Initiative



MacColl Institute at  
Group Health Cooperative



**Five Regional Coordinating Centers (orange) were selected from 42 applicants (blue) to participate**

## Regional Organizations in Five States Supporting 65 Clinics include:

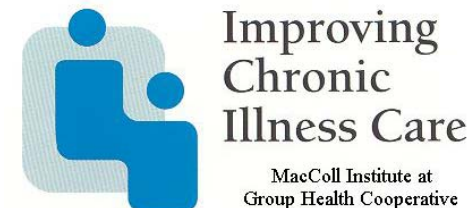
1. Massachusetts League for Community Health Centers and Executive Office of Health and Human Services
2. Oregon Primary Care Association and Care Oregon
3. Colorado Community Health Network
4. Idaho Primary Care Association
5. Pittsburgh Regional Health Initiative



# Qualis Safety Net Medical Home Initiative Identified Eight “Change Concepts”

- **Empanelment**
- **Team-based Continuous Healing Relationships**
- **Patient-Centered Interactions**
- **Engaged Leadership**
- **QI Strategy**
- **Enhanced Access**
- **Care Coordination**
- **Organized, Evidence-based Care**

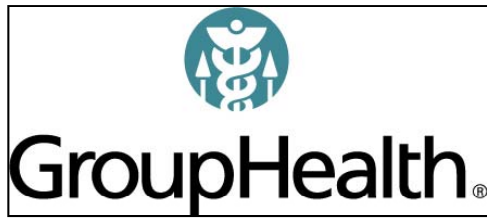
“Implementations Guides”  
for all 8 Concepts available  
free-of-charge at:  
[www.qhmedicalhome.org](http://www.qhmedicalhome.org)



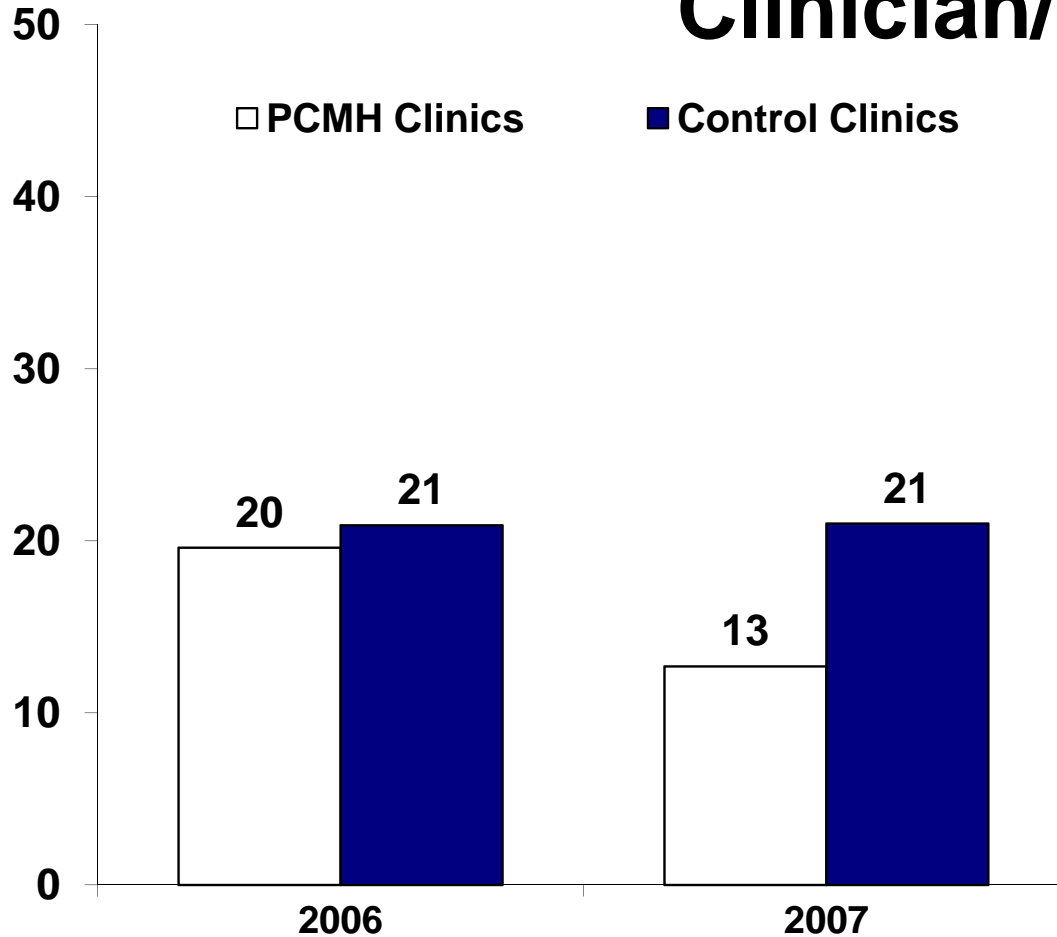
# Key Strategies to Implement Team-Based Care

- 1. Establish and support care delivery teams**
- 2. Link patients to provider and care team so they recognize each other as partners**
- 3. Assure that patients see their provider or team whenever possible**
- 4. Define roles and distribute tasks among team members to reflect skills, credentials, abilities**
- 5. Cross-train team members for flexibility**





# Medical Home Improves Clinician/Staff Satisfaction



## Clinician Emotional Exhaustion

### QUALITY (HEDIS)

- Year 1: Quality improved 2x that of control clinics
- Year 2: Quality improved 20 – 30% more than comparison sites in 3 of 4 composites

### PATIENT EXPERIENCE

- Year 1: Five percent increase in patient activation/goal setting;
- Year 2: Scores continued to improve at Medical Home; controls were slightly worse

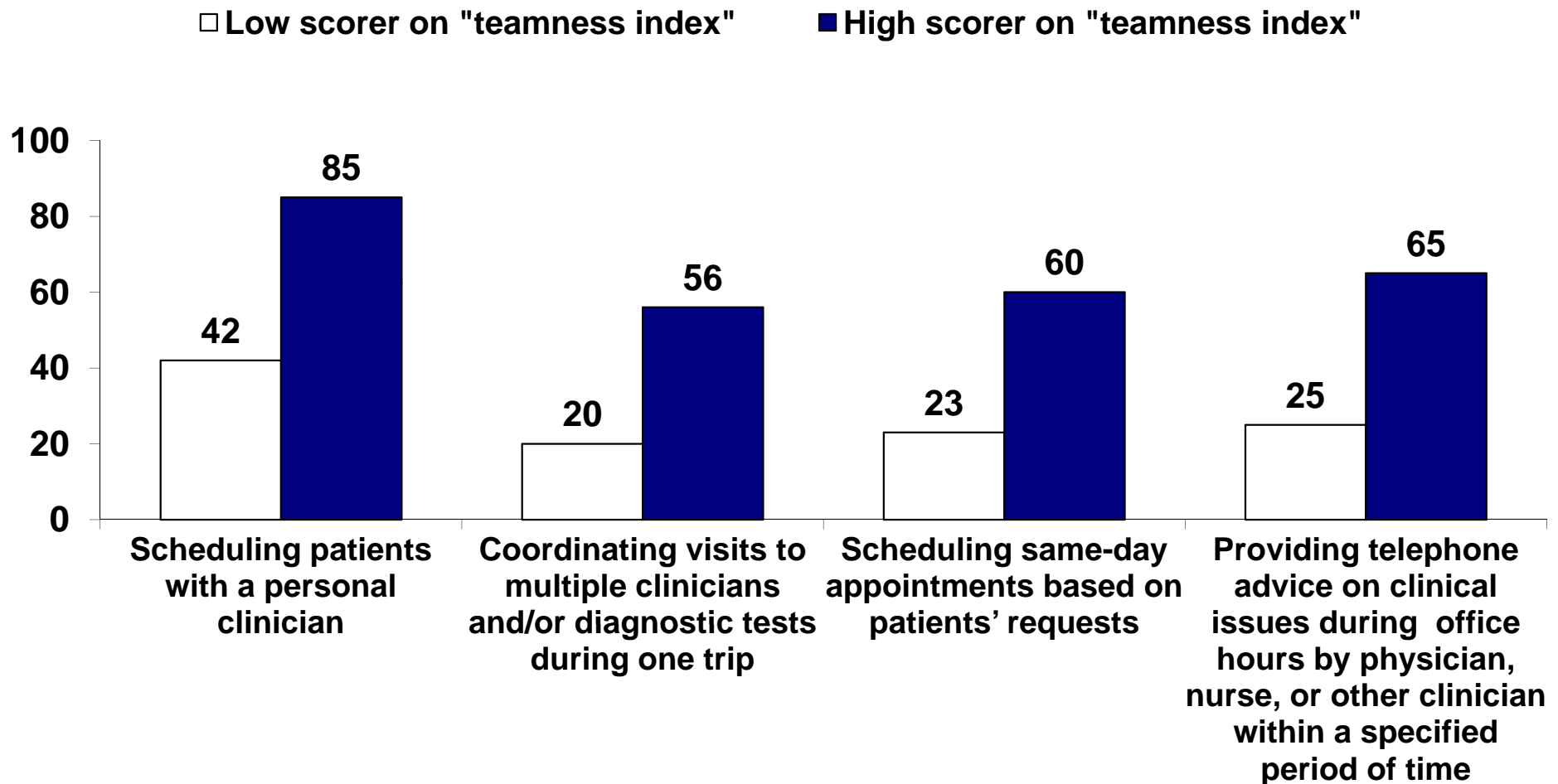
Notes: Mean difference in composite clinical quality changes from 2006 to 2007 between clinics significant at  $p < 0.01$ ; difference in mean emotional exhaustion in 2007 between clinics significant at  $p < 0.01$ .

Source: R.J. Reid, P.A. Fishman, O. Yu, et al., "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation," *The American Journal of Managed Care* 2009, 15(9):e71-e87.





# Safety Net Clinics with Teams Report Better Access, Continuity and Practice Organization

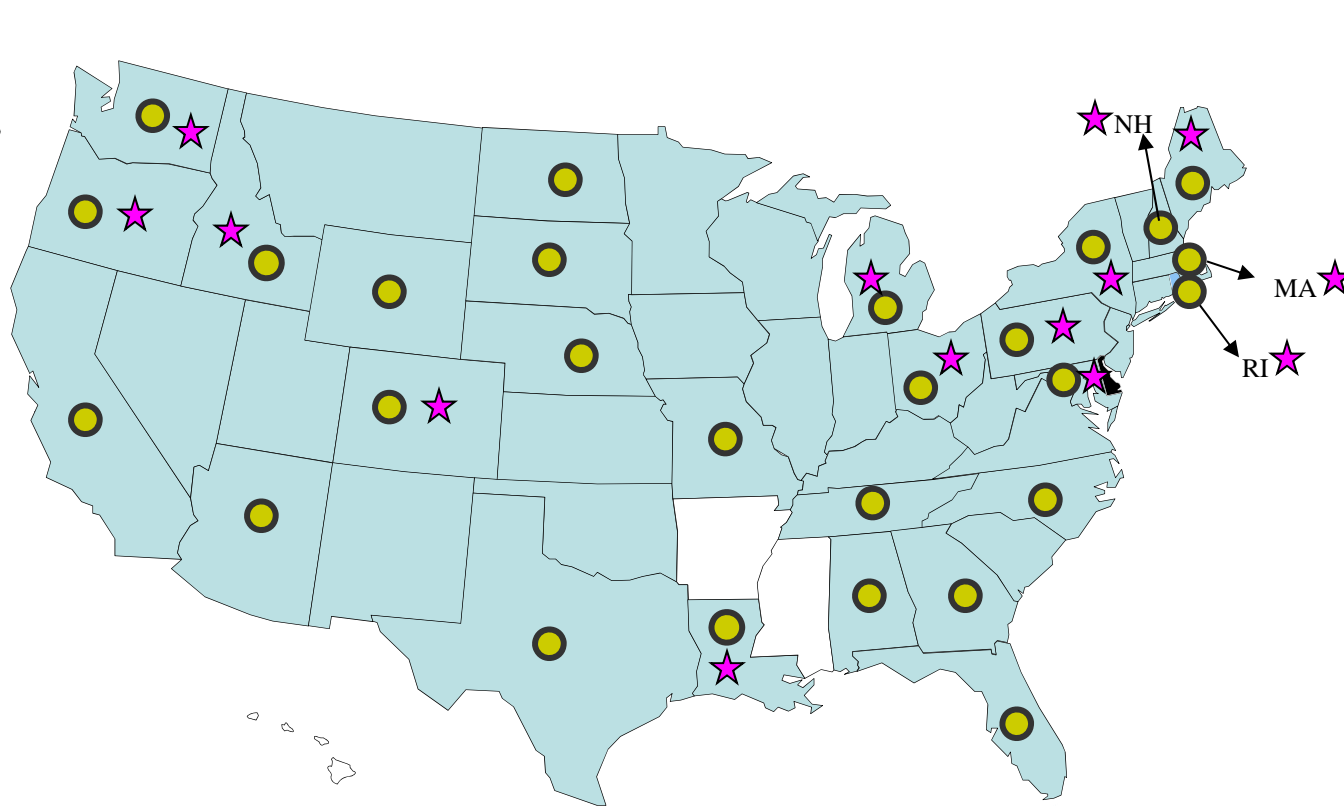


## Overview of Medical Home Demonstrations, Multi-Payer Activity and Evaluations

### 3 Federal Pilots:

1. **Advanced Primary Care pilot with state Medicaid programs**
2. **Medicare FQHC MH pilot program**
3. **Comprehensive Primary Care initiative**

- ★ Independent evaluations
- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 2 States



Source: Patient Centered Primary Care Collaborative, updated October 2011; Commonwealth Fund analysis of PCMH Evaluations



## Health Care Reform Provisions That Impact Primary Care

- **Medicare 10% increase in primary care reimbursement rates, 2011–2016 (\$3.5 billion)**
- **Medicaid reimbursement for primary care increased to at least Medicare levels, 2013–2014 (\$8.3 billion)**
- **32 million more people insured, with preventive and primary care coverage, leading to less uncompensated care**
- **State option to enhance reimbursement to primary care practices for Medicaid patients with chronic conditions (“health homes”)**
- **Innovation Center: medical home pilots a priority**
- **Scholarships, loan repayment, and training demonstration programs to invest in primary care physicians, midlevel providers, and community providers**
- **\$11 billion for Federally Qualified Health Centers, 2011–2015, to serve 15 million to 20 million more patients by 2015**



# Opportunities for Foundations

- **Support transformation to medical homes**
  - **Local, regional quality improvement organization**
  - **Coaching, collaboratives**
  - **Recognition process (fees)**
- **Support providers to adopt capacity for ongoing, continuous quality improvement**
  - **Measurement capacity is critical**
- **Assess progress**
  - **Use nationally recognized measures**
  - **Measure patients' experience**
- **Encourage multi-payer collaboration**
- **Medical homes → medical neighborhoods**



# Thank You!



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