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

RESULTS FROM THE COMMONWEALTH FUND 2006 HEALTH CARE QUALITY SURVEY

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

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Karen Davis, Ph.D., president of The Commonwealth Fund, is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, she received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences;* and *Health and the War on Poverty*.

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EXECUTIVE SUMMARY

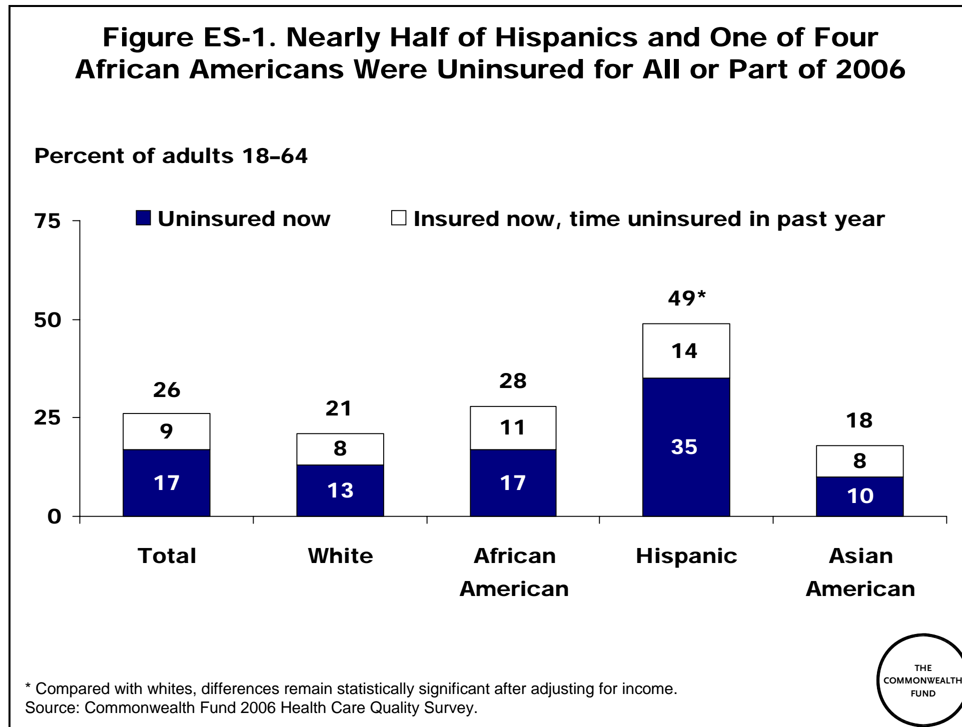
The Commonwealth Fund 2006 Health Care Quality Survey presents new information about interventions that show promise for promoting equity in health care and addressing racial and ethnic disparities in access to high-quality care. Findings from this survey are promising, as they suggest that racial and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

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

Following are some of the key findings of the survey.

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

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



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

- Only 27 percent of adults ages 18 to 64 reported having all four indicators of a medical home: a regular doctor or source of care; no difficulty contacting their provider by telephone; no difficulty getting care or medical advice on weekends or evenings; and doctors' visits that are well organized and running on time (Figure ES-2).

- Many providers do not offer medical care or advice during evenings or weekends. Only two-thirds of adults who have a regular provider or source of care say that it is easy to get care or advice after hours. Compared with other populations, Hispanics are least likely to have access to after-hours care.

- Among adults who have a regular doctor or source of care, African Americans are most likely to have a medical home that provides enhanced access to physicians and well-organized care. One-third of African Americans (34%) have a medical home, compared with 28 percent of whites, 26 percent of Asian Americans, and just 15 percent of Hispanics.

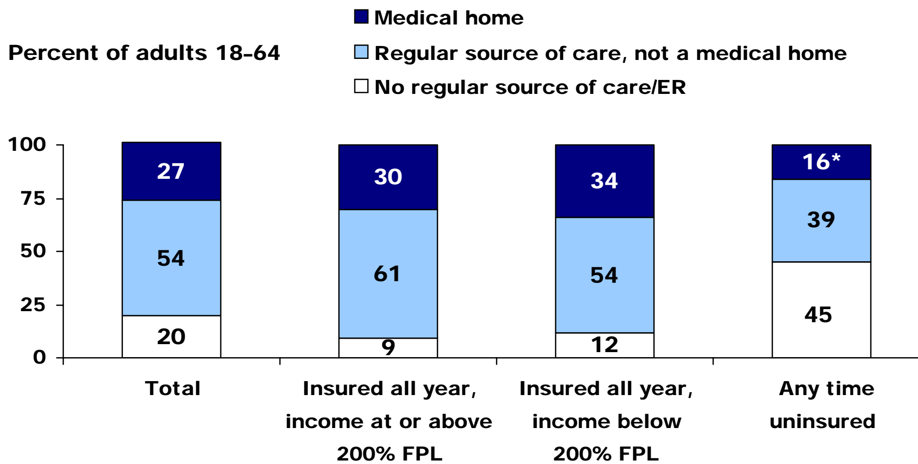
- The uninsured are the least likely to have a medical home. Only 16 percent of the uninsured receive care through a medical home; 45 percent do not have a regular source of care (Figure ES-3).

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

Indicator	Total: Estimated millions	Total: Percent	Percent by Race: 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.

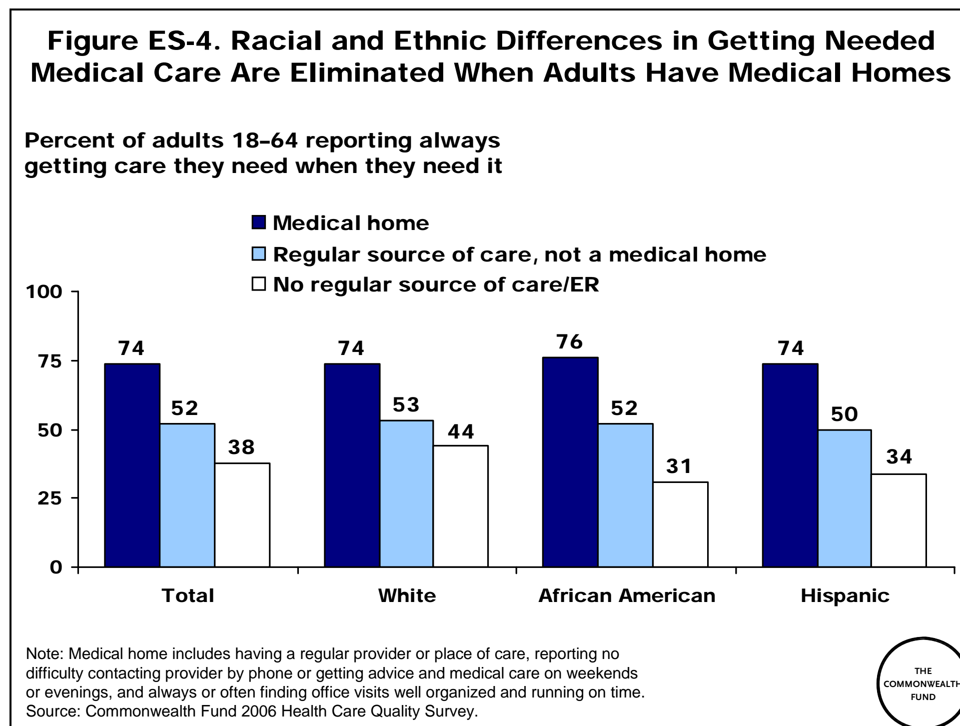
Figure ES-3. Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care



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

Medical homes reduce disparities in access to care.

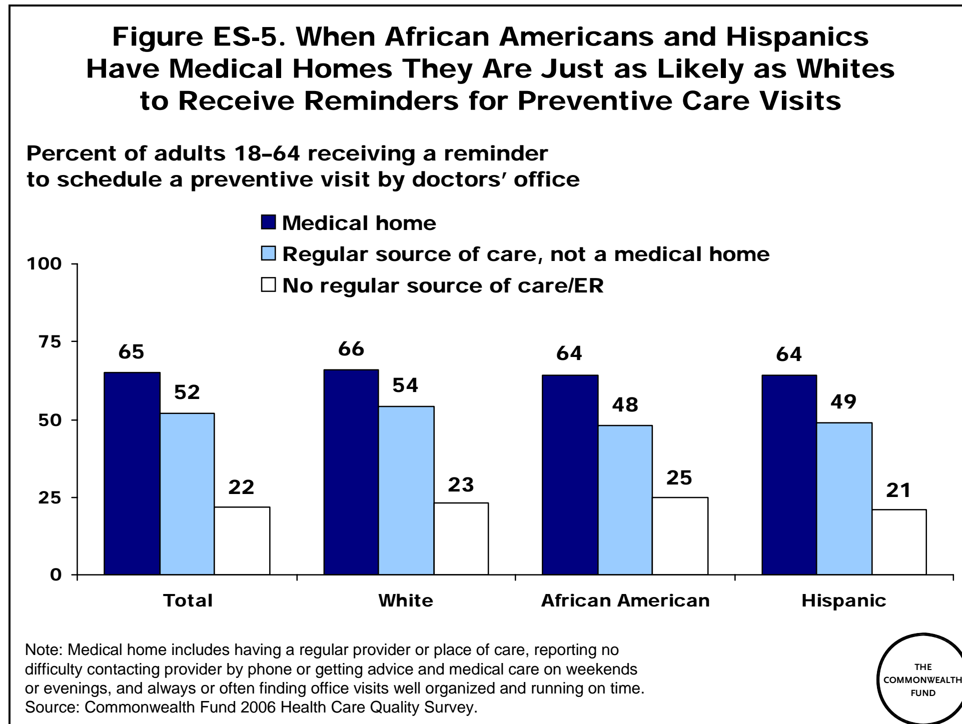
- The vast majority (74%) of adults with a medical home always get the care they need, compared with only 52 percent of those with a regular provider that is not a medical home and 38 percent of adults without any regular source of care or provider.
- When minorities have a medical home, racial and ethnic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



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

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

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

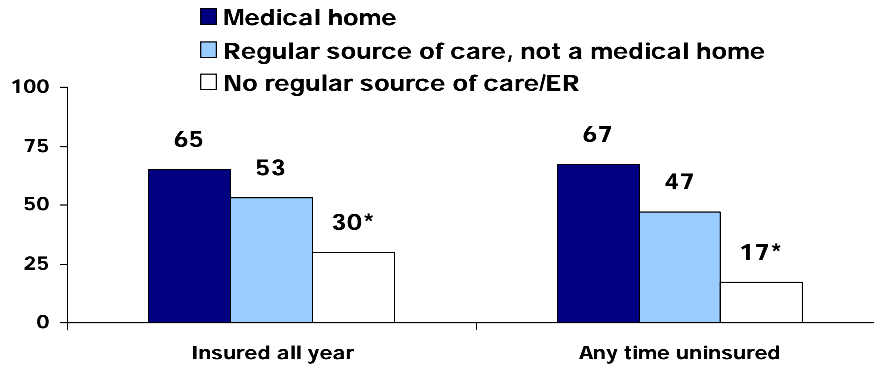


- More than half of insured adults (54%) received a reminder from a doctors' office to schedule a preventive visit, compared with only 36 percent of uninsured adults. When minority populations are insured, they are just as likely as white adults to receive reminders to schedule preventive care.

- Even among the uninsured, having a medical home affects whether patients receive preventive care reminders. Two-thirds of both insured and uninsured adults with medical homes receive preventive care reminders, compared with half of insured and uninsured adults without medical homes (Figure ES-6).

Figure ES-6. Patients with Medical Homes—Whether Insured or Uninsured—Are Most Likely to Receive Preventive Care Reminders

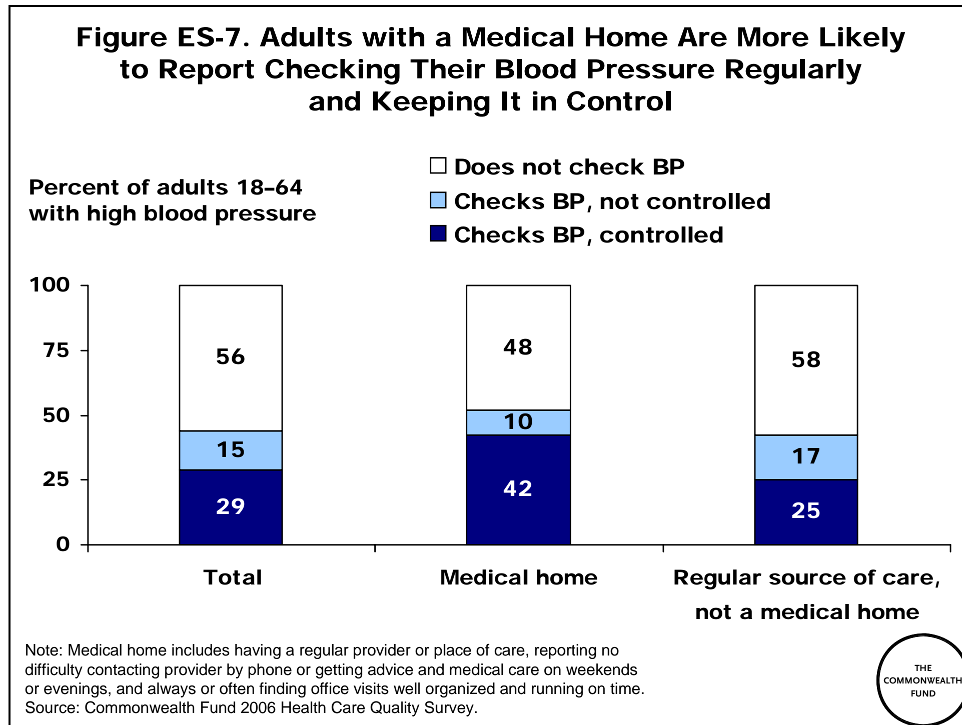
Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctor's office



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

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

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



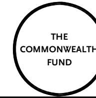
Community health centers and public clinics—which care for many uninsured, low-income, and minority adults—are less likely than private doctors' offices to have features of a medical home.

- The survey finds that community health centers or public clinics serve 20 percent of the uninsured and 20 percent of low-income adults with coverage. In addition, 13 percent of African Americans and more than one of five Hispanics named community health centers or public clinics as their regular source of care.

- Patients who use community health centers or public clinics as their usual source of care are less likely than those who use private doctors' offices to have a medical home. Only 21 percent of adults using community health centers or public clinics reported that they have a regular doctor, have no difficulty contacting their provider by telephone or getting care or medical advice on weekends or evenings, and reported that their doctors' visits are always well organized and running on time. In contrast, 32 percent of patients who use private doctors' offices reported all features of a medical home. Difficulty getting medical advice or care in the evenings or on weekends is more pervasive in community health centers and public clinics than in private doctors' offices or clinics (Figure ES-8).

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

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



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

CONCLUSIONS

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

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

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

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

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

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

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

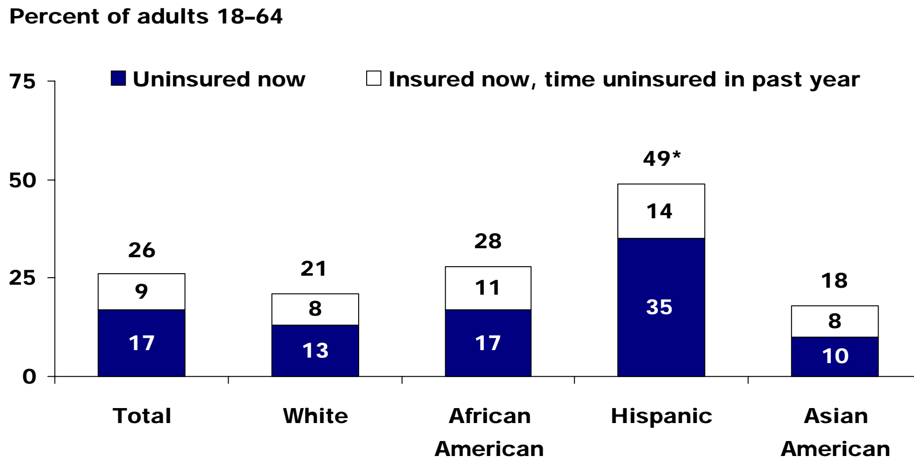
The Commonwealth Fund 2006 Health Care Quality Survey finds that health care settings with features of a medical home—those that offer patients a regular source of care, enhanced access to physicians, and timely, well-organized care—have the potential to eliminate disparities in terms of access to quality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

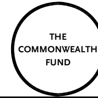
The survey was conducted among a random, nationally representative sample of 3,535 adults age 18 and older living in the continental United States. This report is based on analysis of responses from non-elderly adults ages 18 to 64; respondents are classified by whether they have a regular doctor or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

INSURANCE COVERAGE AMONG AFRICAN AMERICAN AND HISPANIC ADULTS

Uninsured rates in 2006 remained high for African Americans and Hispanics. Among working-age adults ages 18 to 64, nearly half of Hispanics (49%) and 28 percent of African Americans were uninsured during the year, compared with 21 percent of whites and 18 percent of Asian Americans (Figure 1). African Americans and Hispanics are more likely than whites and Asian Americans to be uninsured, in large part because they are less likely to get coverage through their employers. Indeed, although most African Americans and Hispanics live in families in which at least one member is working, rates of continuous health coverage are lower for these minority groups, particularly for Hispanics. Only about half of Hispanics (53%) in families with at least one full-time worker were insured all year, compared with 82 percent of whites and 75 percent of African Americans (Figure 2). Just 43 percent of working-age Hispanics and 54 percent of African Americans have employer-based insurance, compared with 68 percent of whites and 71 percent of Asian Americans (Figure 3).

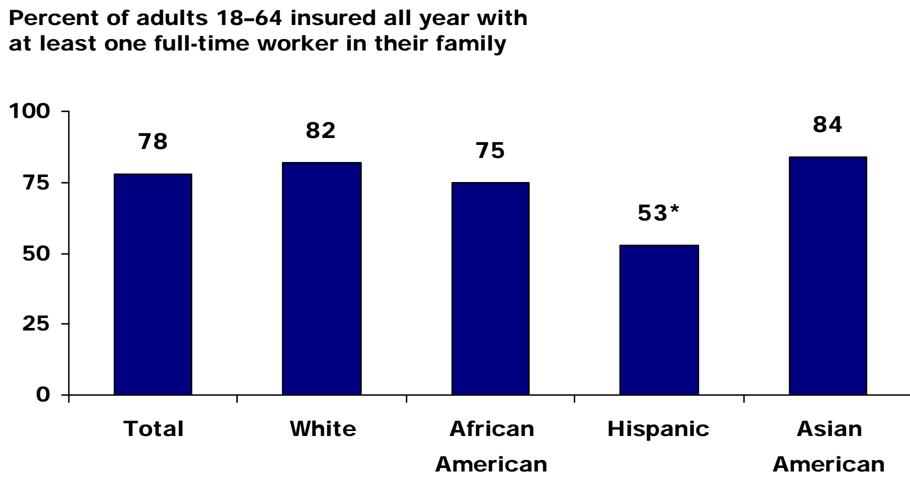
Figure 1. Nearly Half of Hispanics and One of Four African Americans Were Uninsured for All or Part of 2006

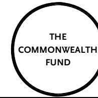




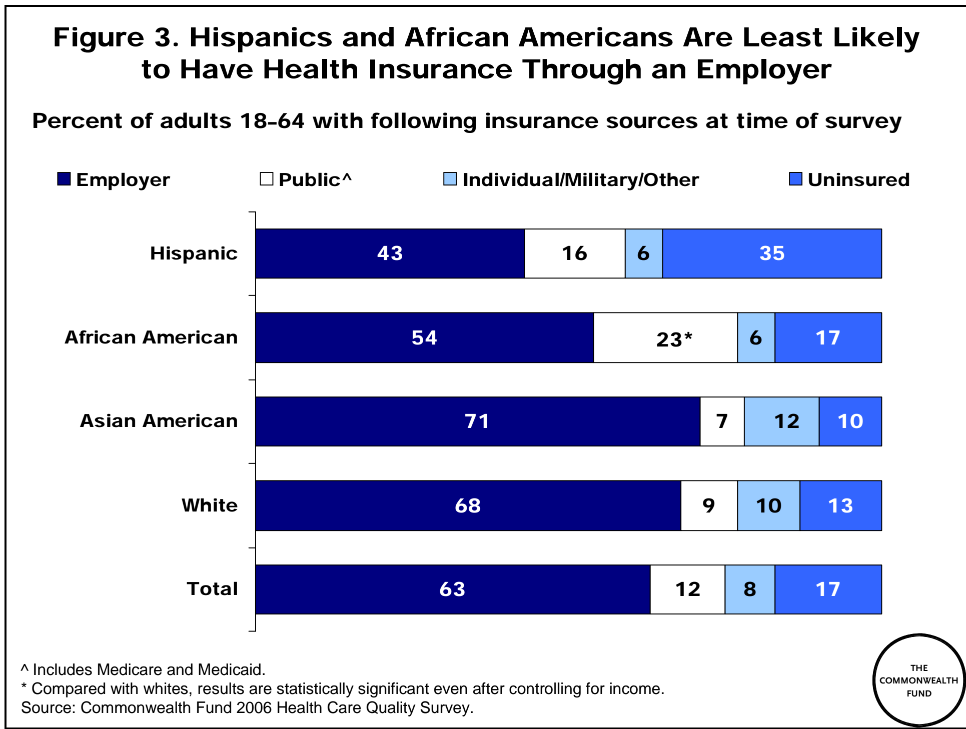
* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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





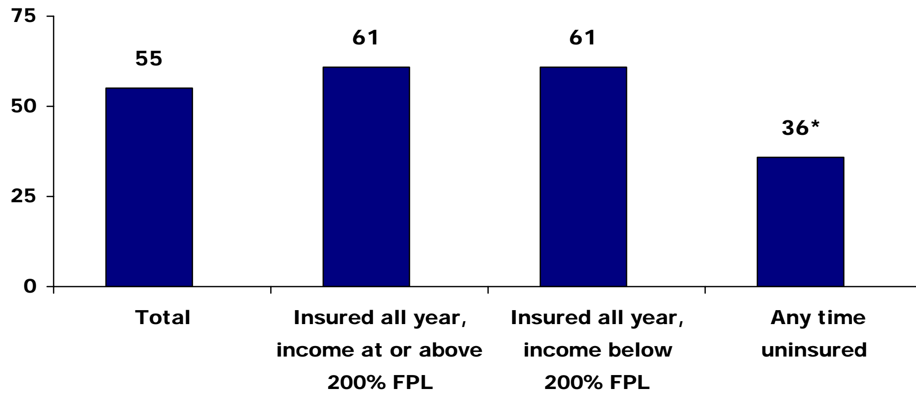
* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.



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

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

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



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

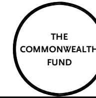
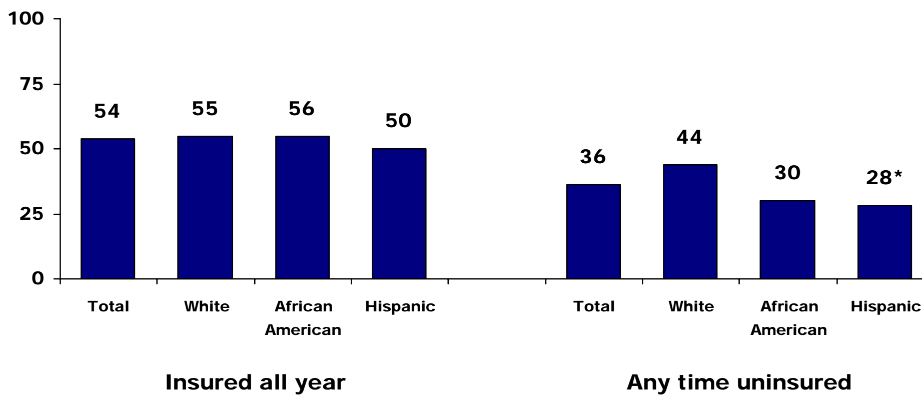
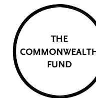


Figure 5. When Insured, Minorities Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits; Rates Are Low for All Uninsured Adults, Especially Hispanics



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



ACCESS TO A MEDICAL HOME

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

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

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

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

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

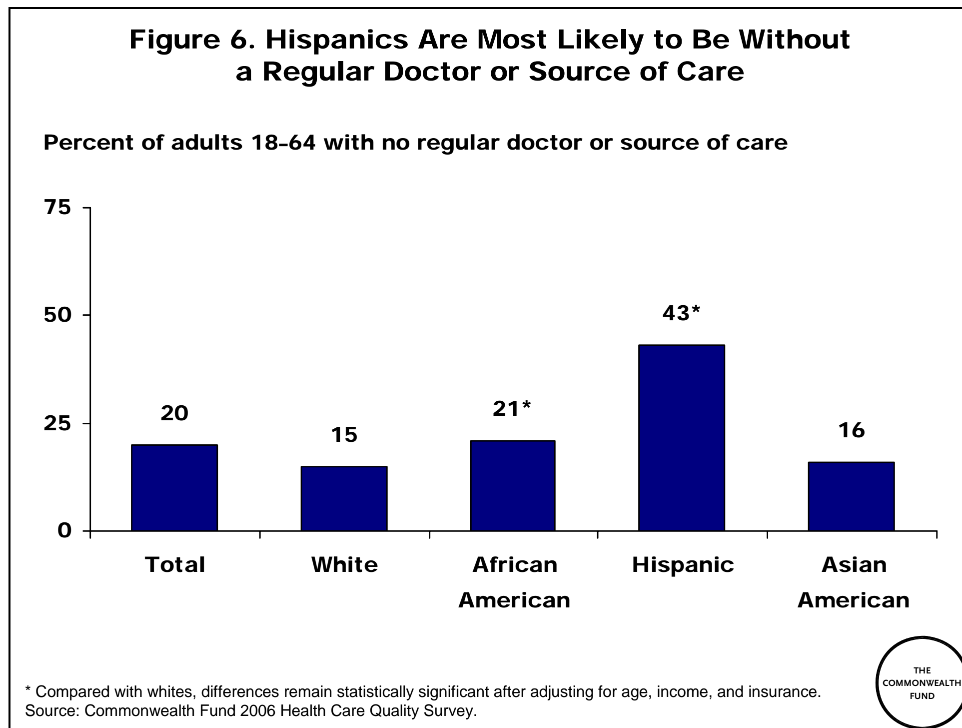
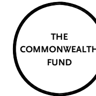


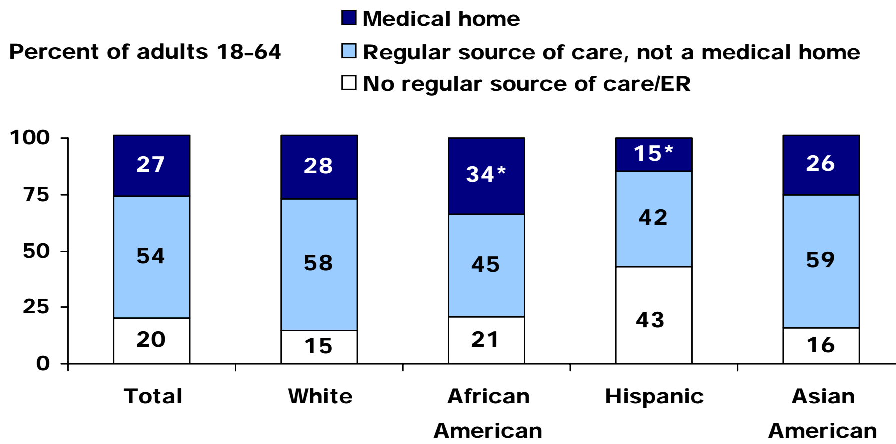
Figure 7. Indicators of a Medical Home
(adults 18–64)

	Total		Percent by Race			
Indicator	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

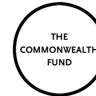


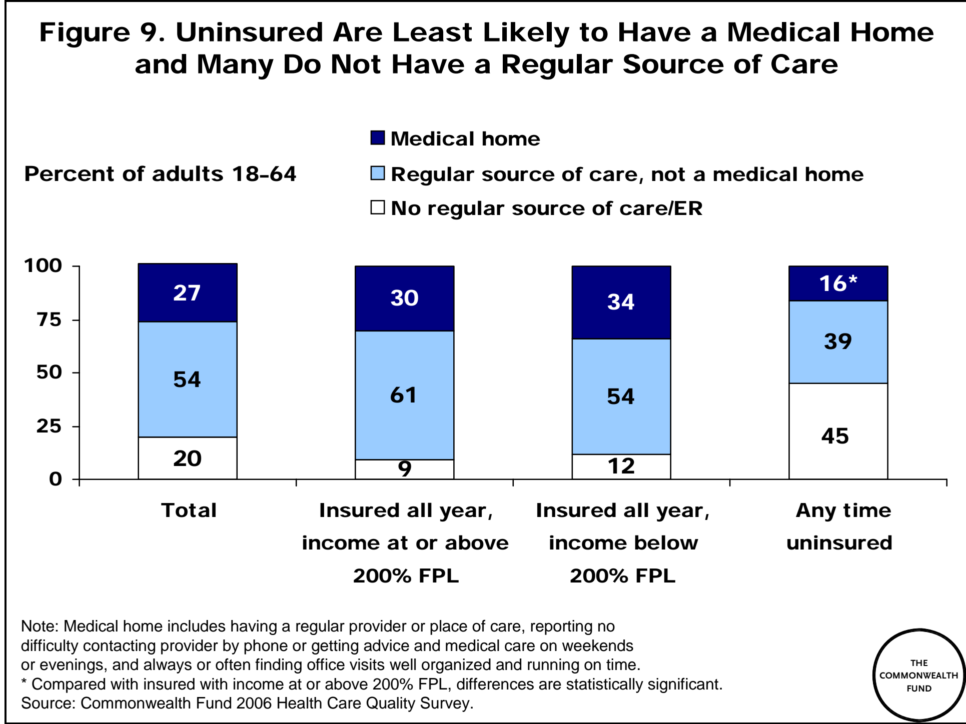
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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



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





TIMELY RECEIPT OF NEEDED CARE AND PREVENTIVE SERVICES

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

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

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

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

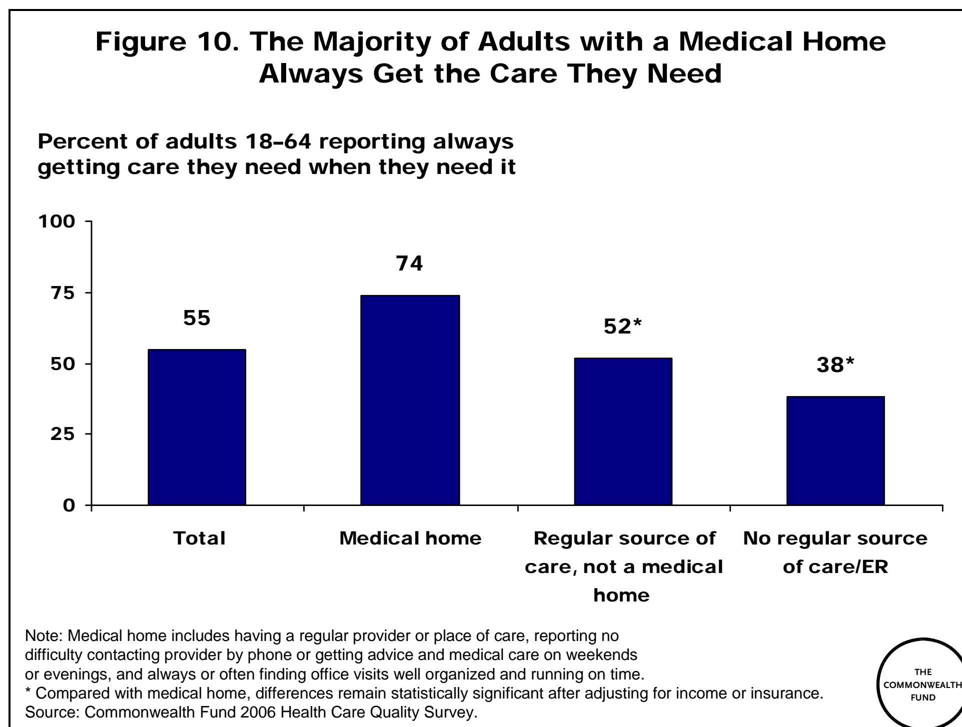
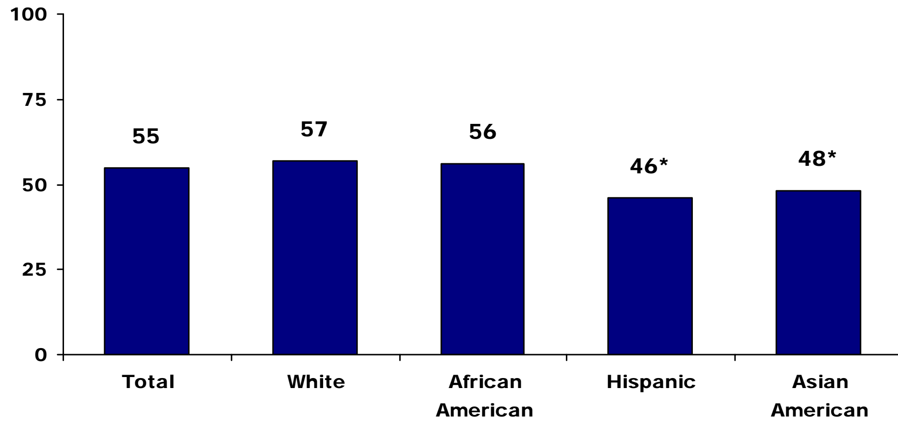
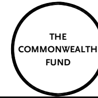


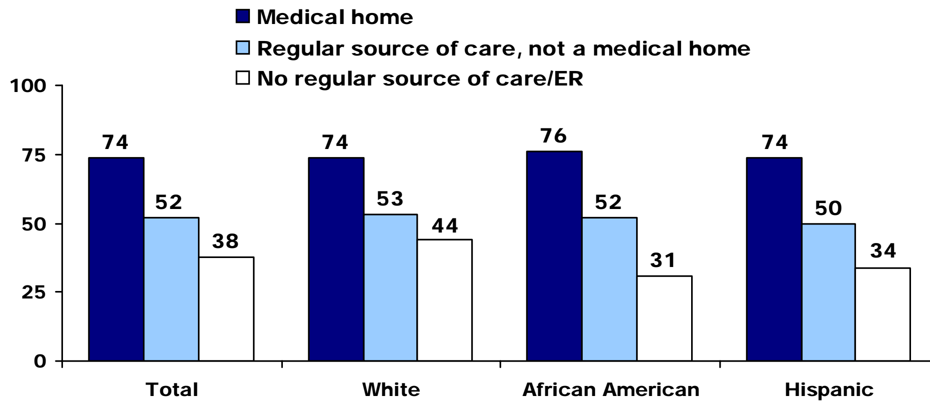
Figure 11. Hispanics and Asian Americans Are Less Likely to Report Always Getting Medical Care When Needed

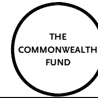




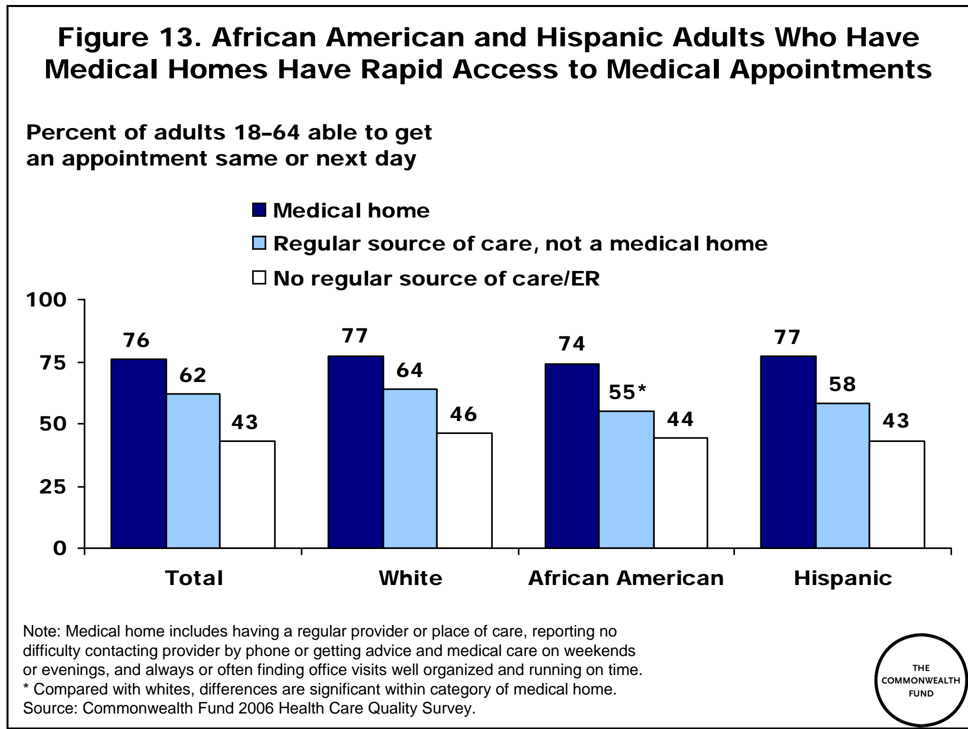
* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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





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



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

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

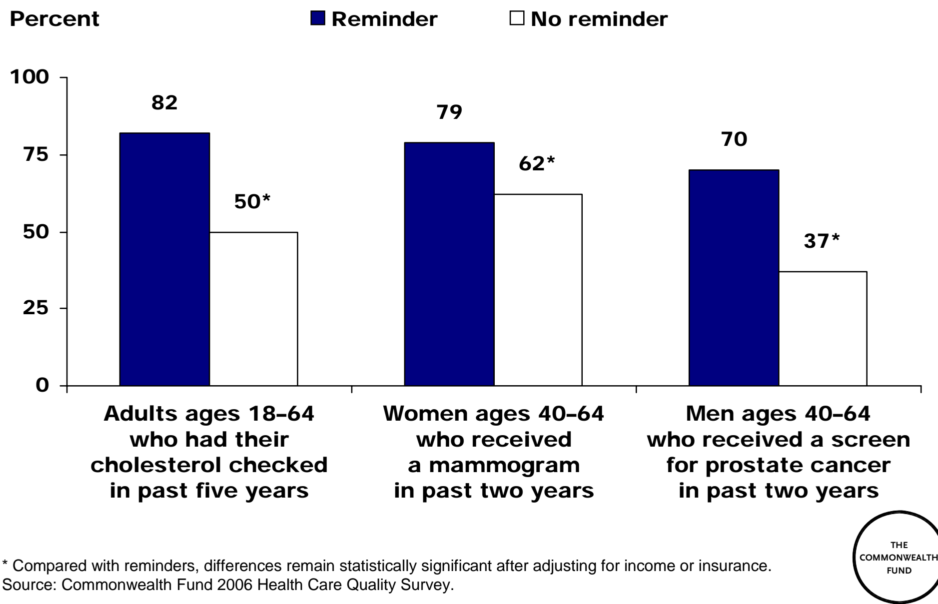


Figure 14. Adults Who Are Sent Reminders Are More Likely to Receive Preventive Screening
Percent
Reminder
No reminder
100
75
50
25
0
82
50*
79
62*
70
37*
Adults ages 18–64 who had their cholesterol checked in past five years
Women ages 40–64 who received a mammogram in past two years
Men ages 40–64 who received a screen for prostate cancer in past two years
* Compared with reminders, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.
THE COMMONWEALTH FUND

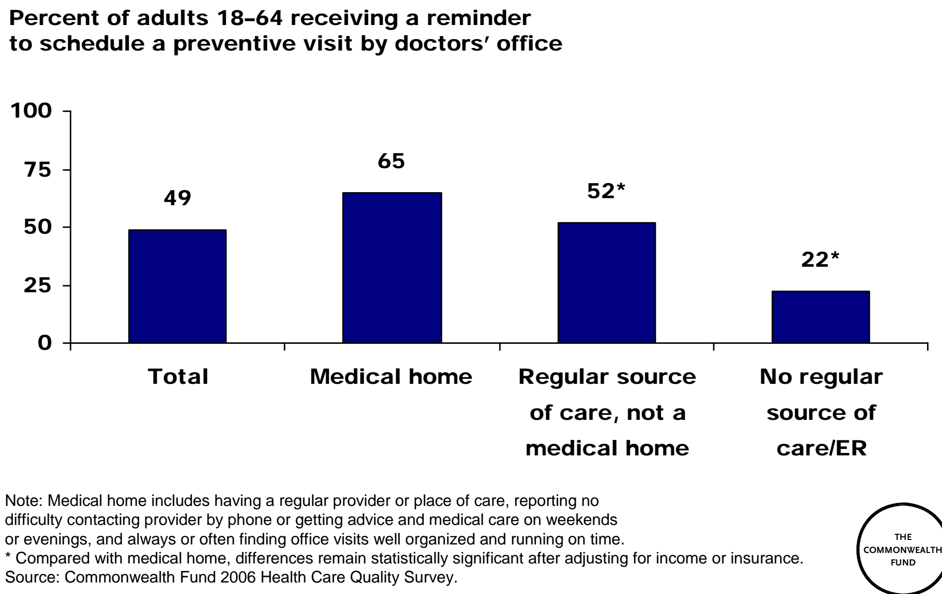
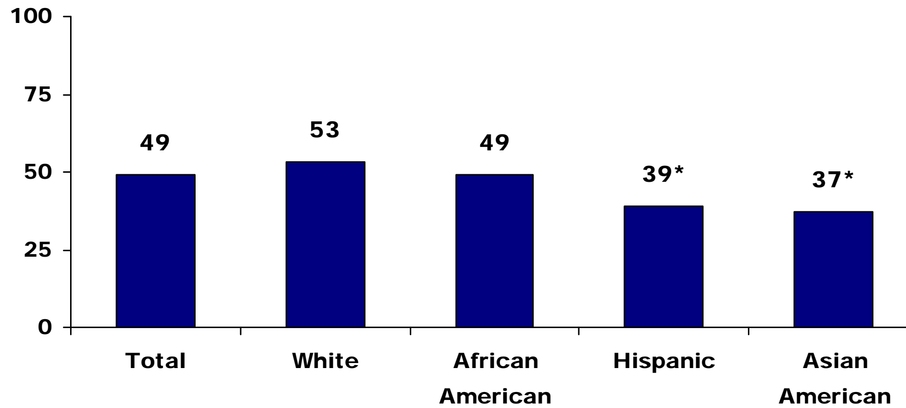


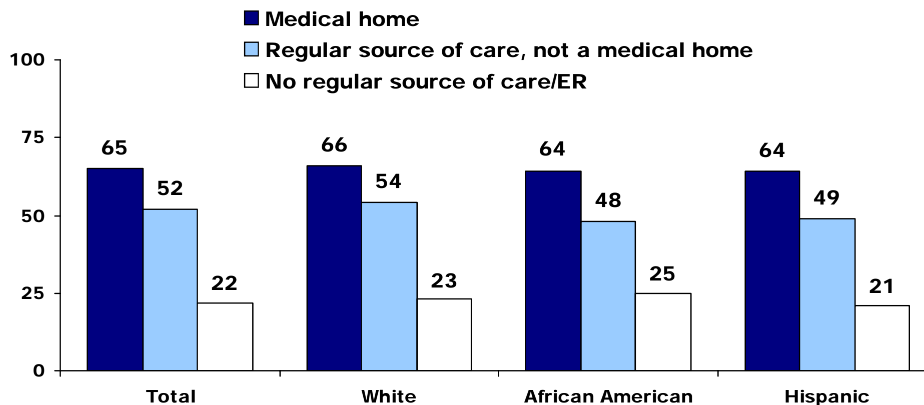
Figure 15. Nearly Two-Thirds of Adults with Medical Homes Receive Reminders for Preventive Care
Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office
100
75
50
25
0
49
65
52*
22*
Total
Medical home
Regular source of care, not a medical home
No regular source of care/ER
Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.
THE COMMONWEALTH FUND

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



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

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



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

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

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

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

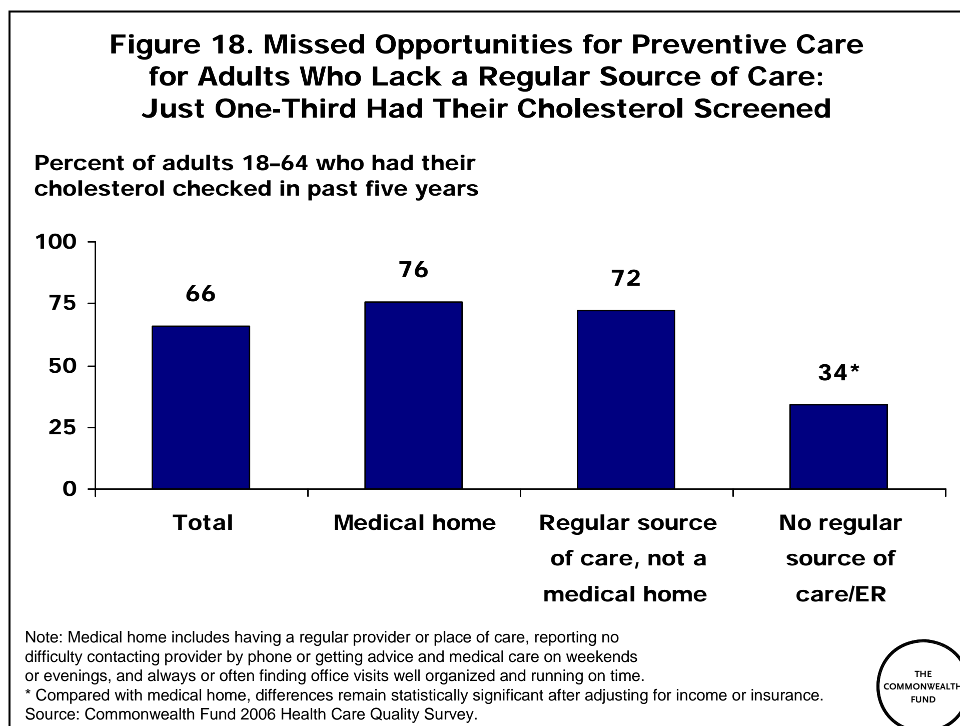
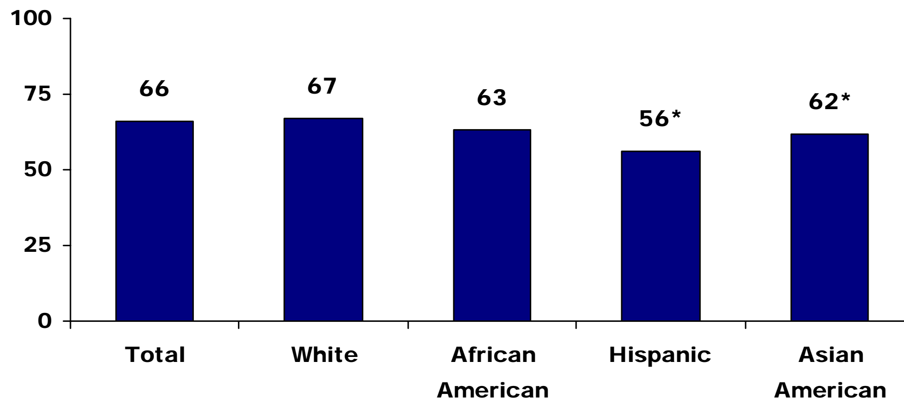


Figure 19. Hispanics and Asian Americans Are Less Likely to Have Their Cholesterol Checked



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

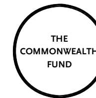
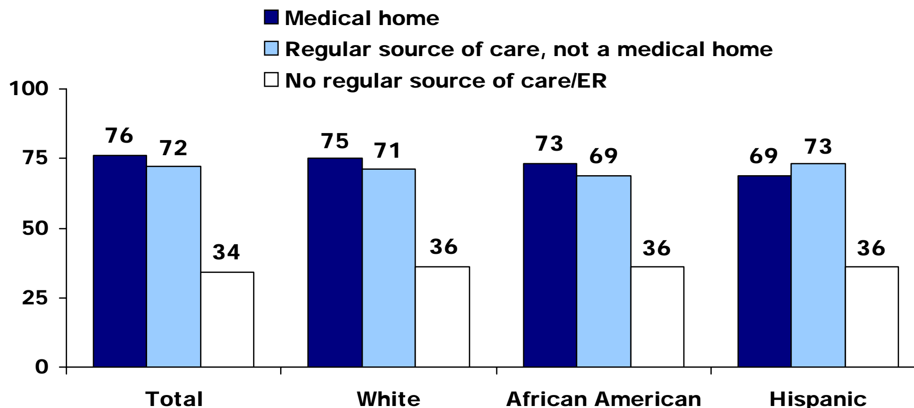


Figure 20. African Americans and Hispanics with Medical Homes Are Equally as Likely as Whites to Receive Cholesterol Checks



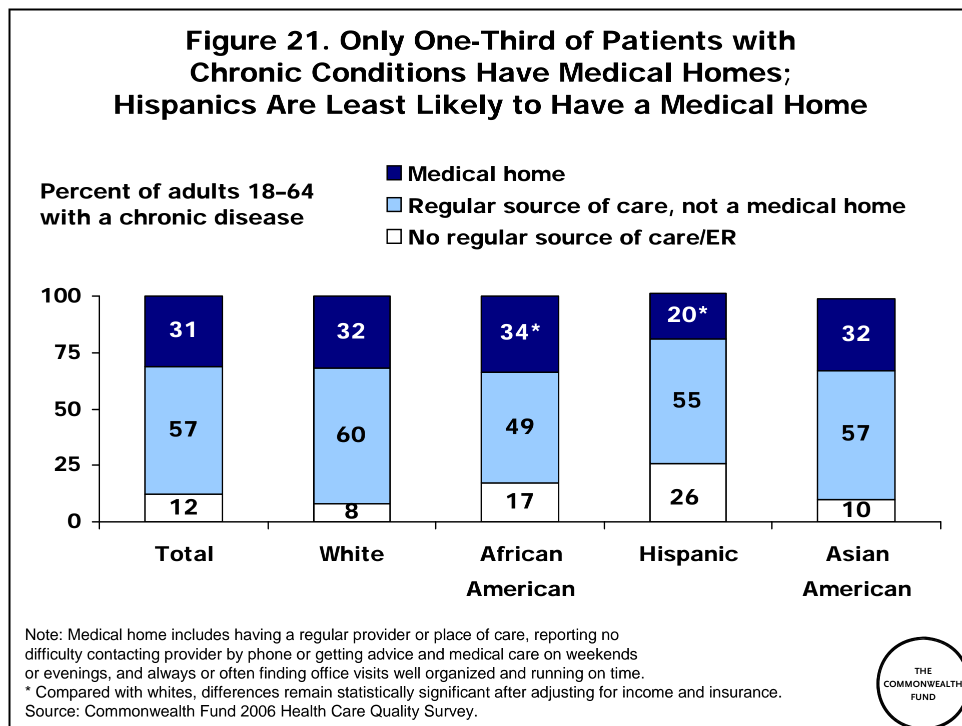
Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health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

MANAGEMENT OF CHRONIC CONDITIONS

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

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

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



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

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

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

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

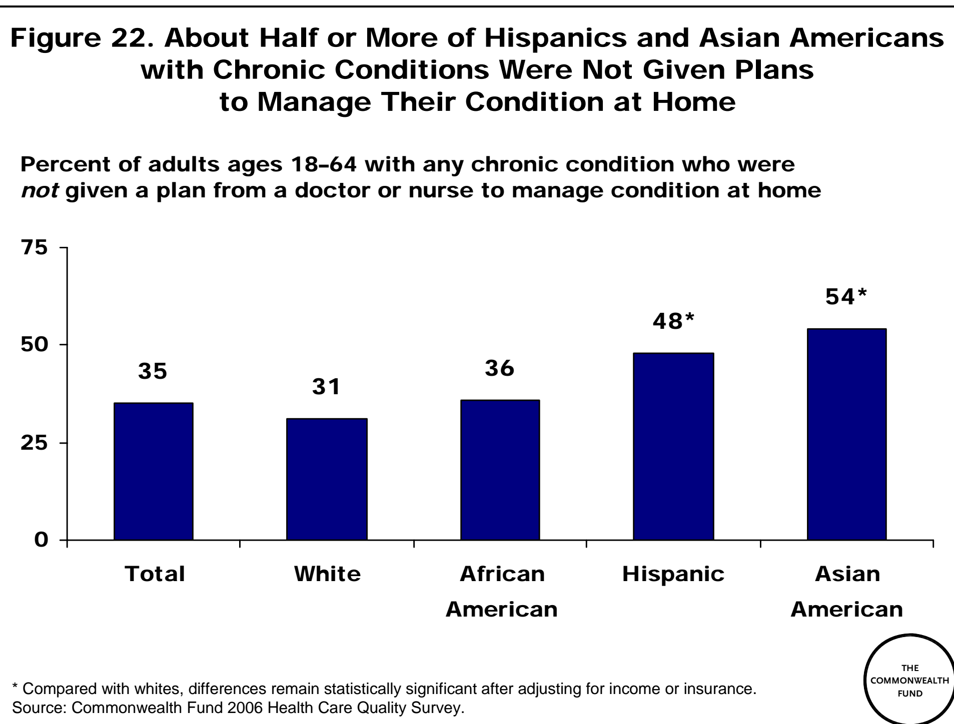
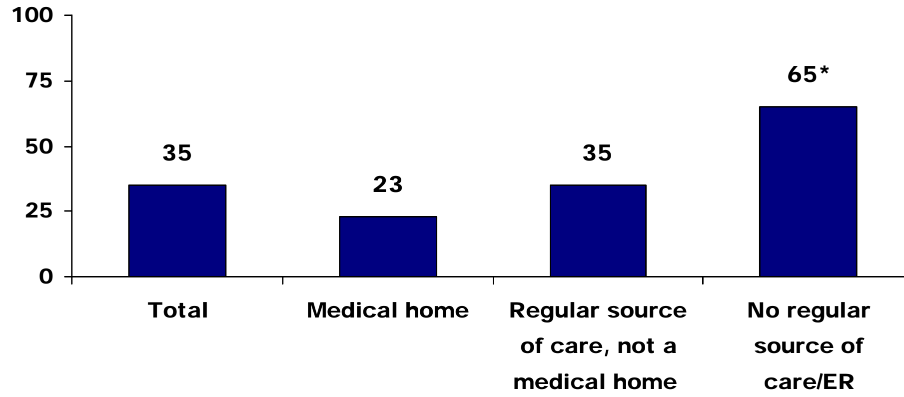


Figure 23. Less than One-Quarter of Adults with Medical Homes Did Not Receive Plans to Manage Their Conditions at Home

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



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

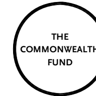
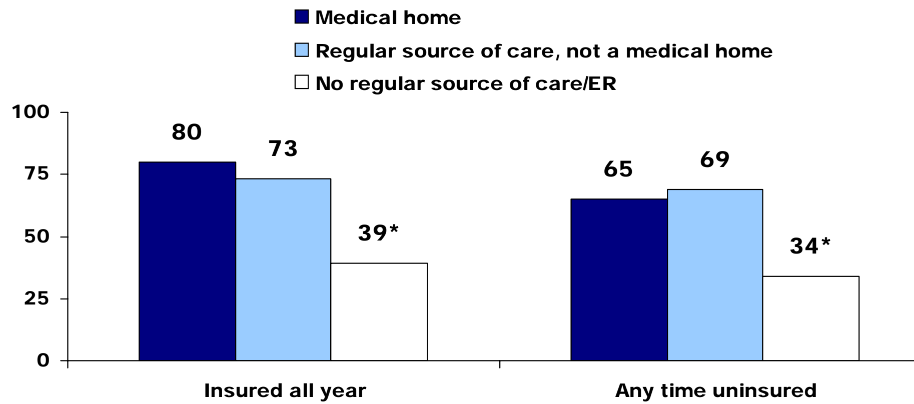


Figure 24. Adults with a Medical Home Have Higher Rates of Counseling on Diet and Exercise Even When Uninsured

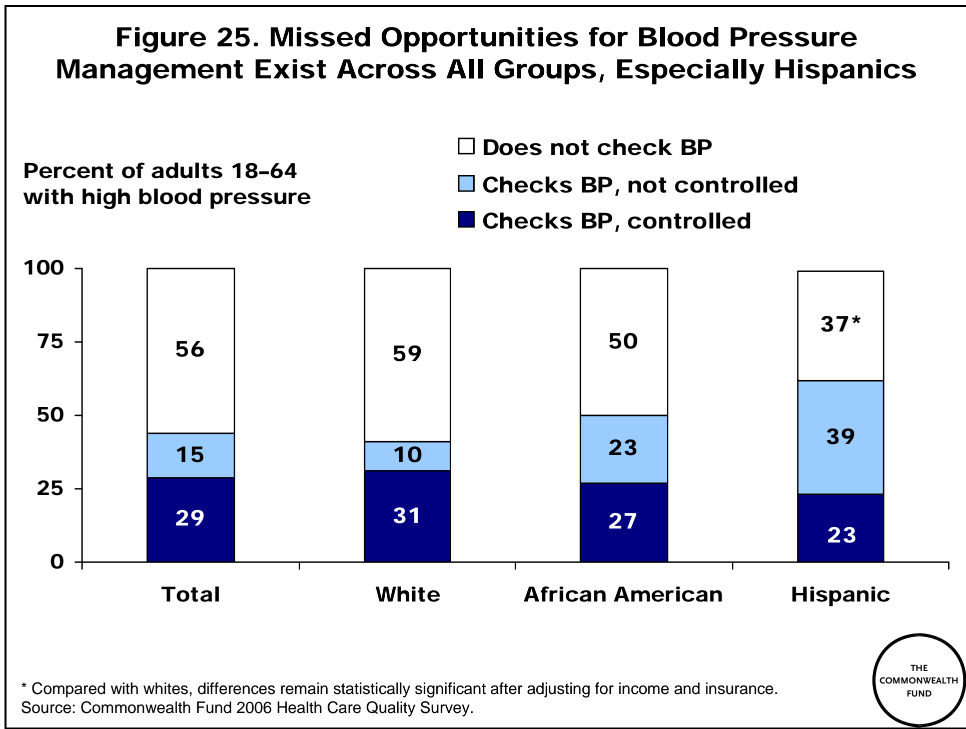
Percent of obese or overweight adults 18–64 who were counseled on diet and exercise by doctor

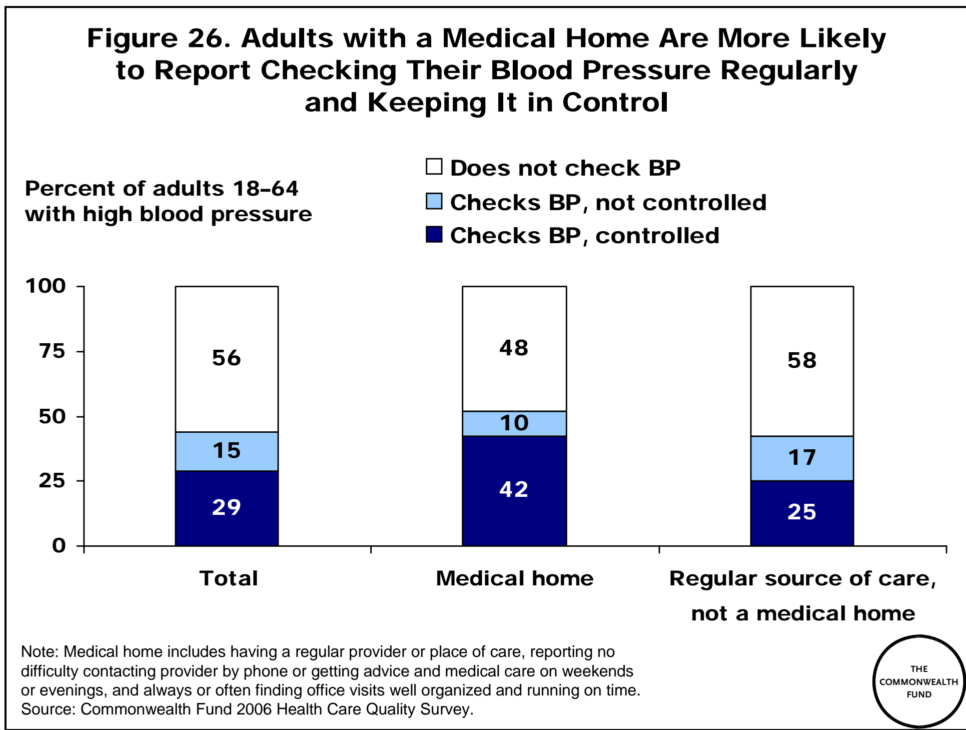


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences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

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

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

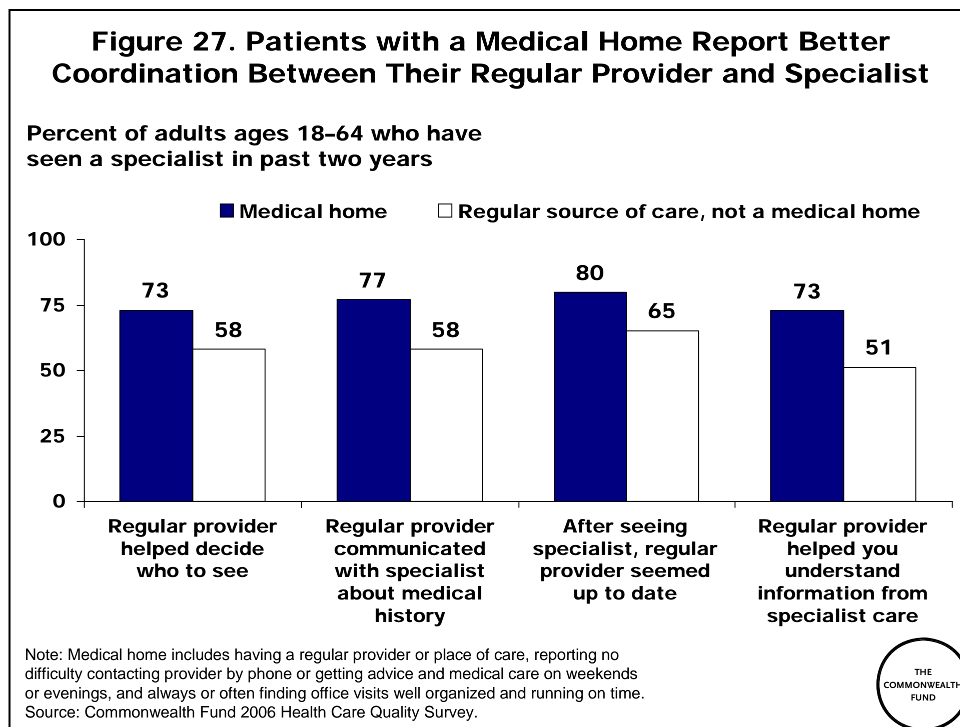




Patients with medical homes have better coordination of care with specialists. In a medical home, care should be effectively coordinated across different domains of the health care system and between providers.[10] Continuity and coordination

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

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

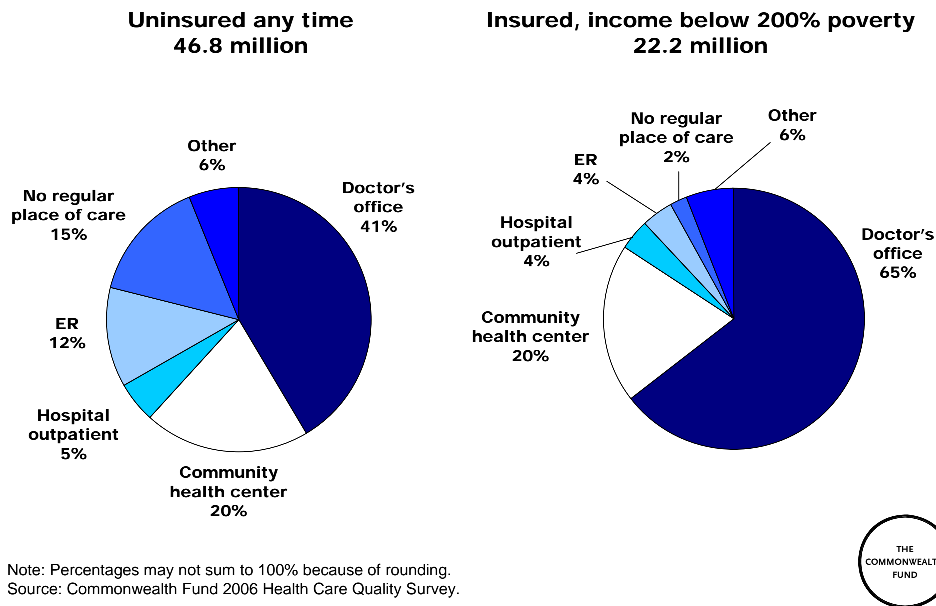


SAFETY NET PROVIDERS

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

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

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



Note: Percentages may not sum to 100% because of rounding.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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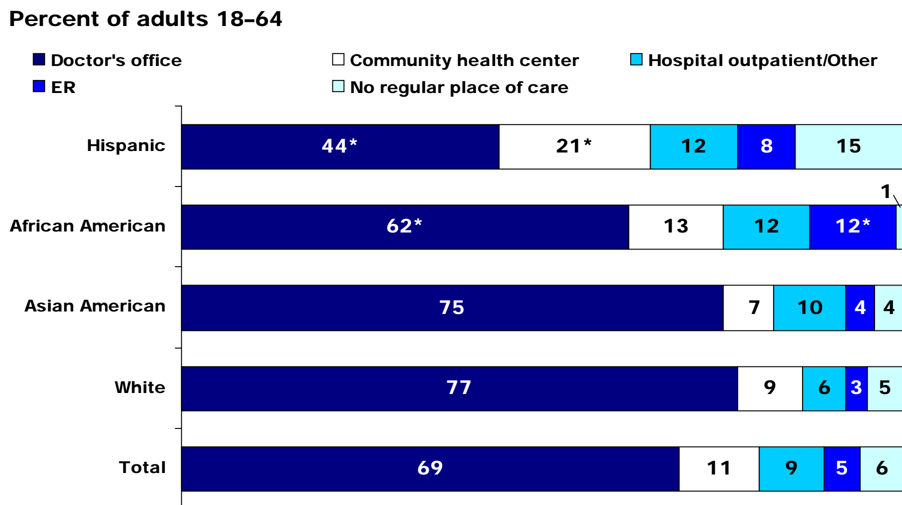
Figure 29. Hispanics and African Americans Are More Likely to Rely on Community Health Centers as Their Regular Place of Care

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.

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

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

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

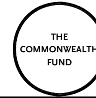
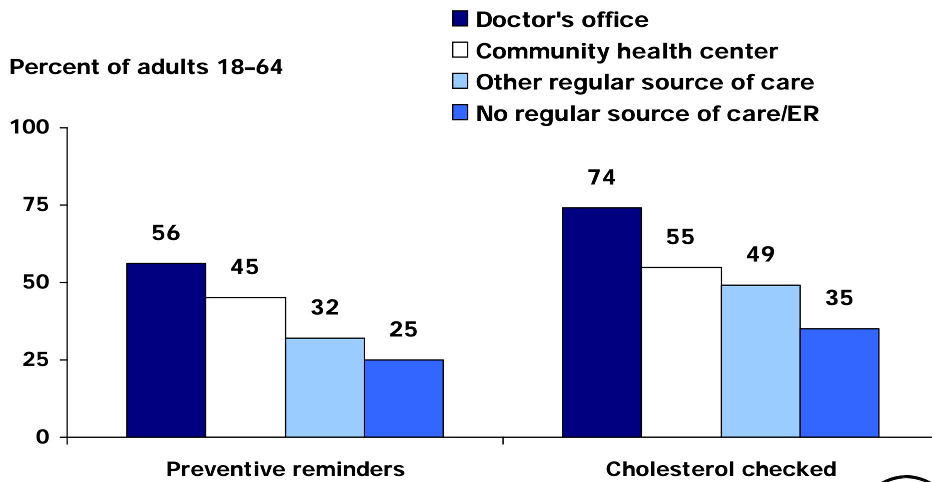
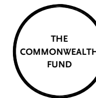


Figure 31. Preventive Care Reminders and Cholesterol Screening Are More Common in Doctors' Offices, But Community Health Centers Are Not Far Behind



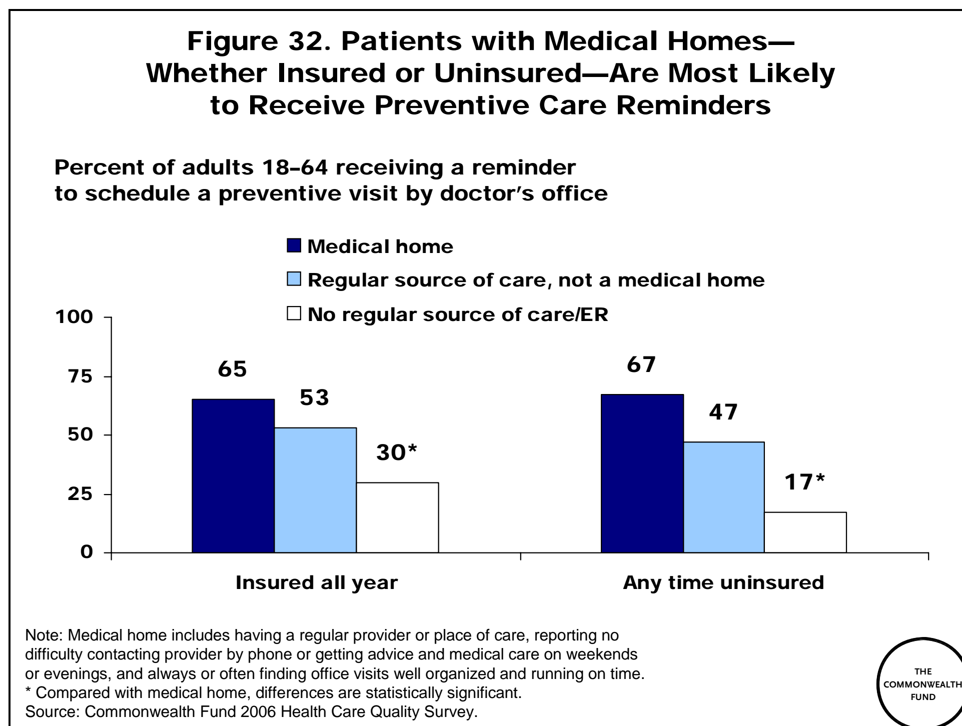
Source: Commonwealth Fund 2006 Health Care Quality Survey.

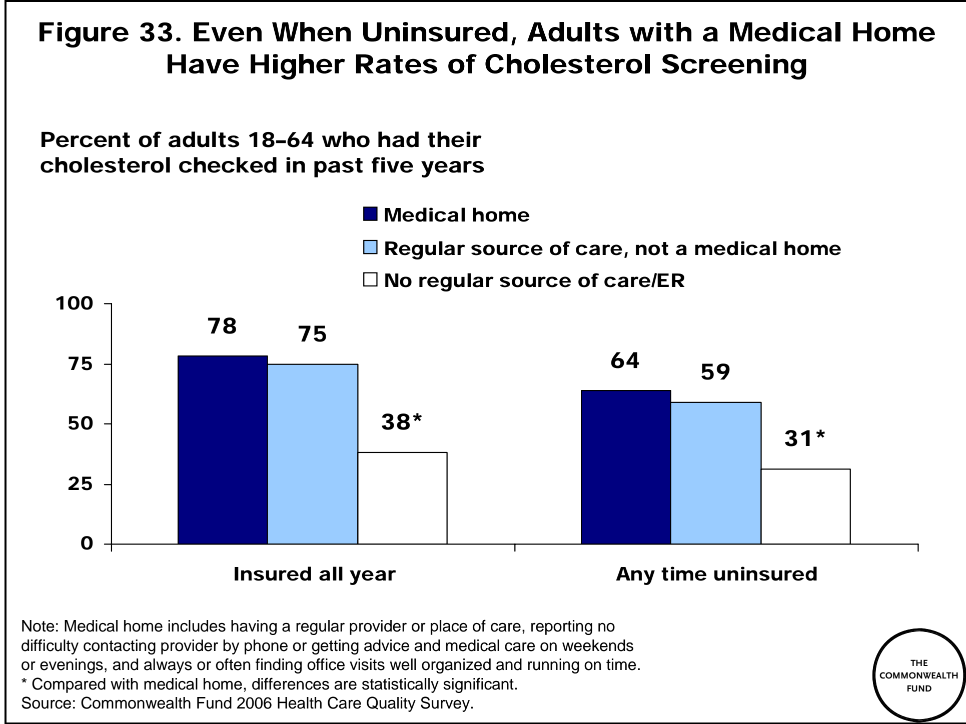


Access to a medical home improves quality and reduces disparities for the uninsured. Safety net providers that function as medical homes not only ensure access to needed care but also provide high-quality care. Compared with insured adults at all income levels, the uninsured are less likely to have a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

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

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





CONCLUSIONS

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

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

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

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

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

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

NOTES

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

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

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

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

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

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

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

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

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

[10] American Academy of Family Physicians et al., "Joint Principles," 2007.

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

APPENDIX A. DATA TABLES

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

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

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

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

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

Source: Commonwealth Fund 2006Health Care Quality Survey.

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

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Unweighted N	2837	650	757	892	455	771	1440	626	1314	422	817
Estimated number of adults (in thousands)	177.3	114.6	20.2	25.0	8.3	47.3	94.9	35.1	89.5	22.2	46.8
Weighted percentages	100%	65%	11%	14%	5%	27%	54%	20%	50%	13%	26%
Timely access to care											
When you think about your health care in general, how often do you receive the health care YOU need WHEN you need it?											
Always	55	57	56	46	48	74	52	38	61	61	36
Often	23	24	21	16	24	19	28	15	26	18	20
Sometimes	13	11	16	17	16	4	15	19	9	15	22
Rarely or never	7	6	6	14	8	1	5	22	3	6	17
When in need of medical attention, how soon are you able to get an appointment?											
Same day or next day	63	66	59	55	54	76	62	43	67	61	53
2 to 3 days	14	14	15	9	20	11	16	10	16	10	13
4 to 5 days	4	4	5	5	3	3	4	3	4	3	6
6 days or longer (includes more than a week, never able to get an appointment, went to ER/UCC)	17	14	19	26	18	8	15	38	12	24	25

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Preventive care											
Doctor's office reminded you to schedule preventive care	49	53	49	39	37	65	52	22	55	58	36
Cholesterol checked in past five years	66	67	63	56	62	76	72	34	73	65	47
Received mammogram in past two years (women ages 40–64)	73	73	77	76	78	79	74	49	80	76	44
Received blood test or rectal exam for prostate cancer in past two years (men ages 40–64)	52	54	57	39	54	77	47	34	55	64	35
Physician counseling in past two years											
Doctor discussed about the health risks of smoking and ways to quit (among smokers)	72	74	73	52	62	84	82	42	77	87	59
Doctor discussed exercise and having a healthy diet and weight	60	61	65	54	57	70	66	31	65	67	46
Doctor discussed any emotional concerns you may be affect your health	26	27	26	25	16	28	28	18	24	43	26

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

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

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 3. Chronic Disease Management and Coordination of Care by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status

Base: Adults 18–64

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Adult with a chronic disease (Unweighted N=)	**934**	**246**	**348**	**211**	**100**	**297**	**512**	**125**	**437**	**185**	**221**
Chronic disease management											
Was not given plan to manage condition at home	35%	31%	36%	48%	54%	23%	35%	65%	27%	30%	56%
How confident are you that you can control or manage your health problems?											
Very confident	68	72	63	57	62	75	65	65	73	66	66
Somewhat confident	23	21	28	24	25	20	24	19	21	24	20
Not too/Not at all confident	5	3	7	15	10	2	6	13	3	8	8
Adults with high blood pressure or heart disease (Unweighted N=)	**511**	**139**	**201**	**103**	**56**	**153**	**290**	**68**	**257**	**87**	**119**
Management of high blood pressure											
Does not check blood pressure regularly	56%	59%	50%	37%	—	48%	58%	—	51%	56%	65%
Checks blood pressure regularly, BP not in control**	15	10	23	39	—	10	17	—	16	16	16
Checks blood pressure regularly, BP is controlled	29	31	27	23	—	42	25	—	33	28	19
Was not given plan to manage condition at home	34	30	34	54	—	24	33	—	27	37	50
Not too/Not at all confident can control or manage health problem	6	3	8	19	—	2	5	—	2	10	11

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Adults who have seen specialist in last two years (Unweighted N=)	**1075**	**328**	**312**	**221**	**171**	**342**	**699**	**34**	**641**	**175**	**163**
Coordination of care between specialist and regular doctor											
Regular provider helped decide who to see	62%	61%	62%	62%	74%	73%	58%	—	60%	77%	60%
Regular provider communicated with him/her about medical care or history	63	62	69	65	54	77	58	—	60	82	62
Saw a specialist and regular provider seemed informed and up-to-date	70	68	72	73	69	80	65	—	66	87	70
Regular provider helped you understand about care received from specialist	57	54	62	65	55	73	51	—	54	73	59

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

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

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

Source: Commonwealth Fund 2006 Health Care Quality Survey.

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

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

Source: Commonwealth Fund 2006 Health Care Quality Survey.

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

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

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

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

Source: Commonwealth Fund 2006 Health Care Quality Survey.

APPENDIX B. SURVEY METHODOLOGY

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

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

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

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

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