Examining The Medical Home: A Solution To ACA

Introduction:

President Obama signed the Affordable Care Act (ACA) into law in 2010 and since then millions of Americans have gained health insurance. However, this increase in the number of insured individuals has led to the need for an increased supply of primary care physicians, approximately 52,000 additional physicians by 2025. More specifically, there is a need for an increase in supply of quality and effective health care for those insured. The United States spends the most capita on health care in comparison to other developed nations, but ranks significantly lower in health outcomes, effectiveness, and equity of care. Therefore, the United States’ ability to meet this demand, while minimizing costs, will require innovative restructuring of primary care delivery.

This paper explores an innovative model of care delivery, referred to as the “medical home”, which could provide a solution to meet the increased demand for primary care physicians, while ensuring quality care and minimizing health care costs.

This paper will explore the effects of the medical home on cost of care, health outcomes, and equity of care. Moreover, through the analysis of the principles of the medical home model, this paper will provide policy implications to address the increase in demand for primary care physicians caused by the Affordable Care Act.

Background:

In 1967 the medical home term was introduced by the American Academy of Pediatrics (AAP) as a central source for all of the medical information of a child. Then in 2007 the AAFP, ACP, and AOA joined AAP to redefine the “medical home” concept as a model of comprehensive primary care with six main attributes. The first attribute of the model is that each patient has an ongoing relationship with a personal primary care physician. The second, third, fourth, and fifth attributes are physician directed medical practice, increased quality and safety, enhanced access, and payment reform respectively. The sixth attribute of the model is coordinated care, in which all elements of the patients’ communities and health care system are managed.

The medical home model’s emphasis on primary, patient-based care, can lead to decreased morbidity and mortality associated with non-communicable diseases and in turn lead to decreased health care costs. The model’s emphasis on personal physician and coordinated care services can lead to higher quality and effectiveness of care. Therefore, through the analysis of large cross-national studies as well as a specific medical home pilot program in North Carolina, Community Care, this paper explores the effects of the medical home.

Literature Review:

I. Health Care Costs

Through the medical home’s emphasis on a personal physician, payment reform, and increased quality and safety, the implementation of the model is exemplified to minimize overall health care costs. In a comparison between the Seattle-based Group Health clinics with its medical home pilot, patients in the medical home had an average of directly $10.30 savings per patient per month after twenty-one months into the pilot program. The savings observed were in part due to the decrease in emergency visits and hospitalizations seen in medical home patients. Around half of chronically ill adults in the United States
have forgone care, skipped medications because of cost. Therefore, through the medical home model’s emphasis on ongoing care with a personal physician, the costs of acute care, such as emergency visits, are minimized.

Furthermore, the enhanced access attribute of the medical home model, which involves more open scheduling, expanded hours, and new methods of communication, was seen to minimize costs in the Seattle medical home pilot project. It was identified that although there was a decrease in in-patients visits, there was an increase in alternate forms of communication such as message threads and telephone within the medical home clinics. This was correlated with the reduction in health care costs, a $1.50 return for every $1.00 spent for a patient. The enhanced access attribute of the medical home model, leads to greater communication between physicians and patient and in turn decreases health care costs.

Furthermore, the medical home model’s attribute of payment reform, in which the cost of visits and use of technology are minimized, also contribute to lower costs. Through both the emphasis on payment reform and quality of care, the decision-making of physicians is oriented around individual patients and patients’ feedback. This emphasis on patient-centered care may cost less because patients experience less duplication and more appropriate use of technology. The average health care cost of Community health centers for primary care medical homes in United States is almost $2,000 less than the cost for the general population. Moreover, through North Carolina’s Community Care partnership with hospitals, social services, and other community networks, the project saves the state more than $160 million annually. Therefore, the medical home model is both cost-effective for patients and lowers overall health care expenditures.

II. Health Outcomes

The medical home model has shown to provide improved quality of care, patient satisfaction, and reduced errors. Due to the emphasis on a longstanding physician-patient relationship, physicians’ are able to better understand a patient’s behavior and provide appropriate treatment. Studies have shown that 70% of health care errors are related to the failure of physician-patient communication. Moreover, continuity of care with a personal physician or enhanced physician-patient relationship is associated with increased patient satisfaction as well. Additionally, access to a regular, primary care physician is consistently associated with increased life span and better overall health outcomes, including decreased rates of mortality from heart disease and cancer, neo-natal mortality, and low birth weight. Therefore, the medical home model’s principles of personal physician, holistic care and coordinated care lead to improved health outcomes.

Furthermore, the medical home model’s principle of increase in quality of care has shown to lead to improved health outcomes as well. The North Carolina Community Care program noted an overall increase in health status according to the National Committee for Quality Assurance benchmarks. Specifically, they noted 112% increase in the number of asthma patients who received influenza vaccinations and a decrease in emergency department visits and hospitalizations for children with asthma. Within the medical home model, the support of a regular, primary care physician is associated with an increase in preventative screenings, chronic illness care, and monitoring medication. Therefore, the medical home model’s attributes of increase in quality, access to a personal physician,
and coordinated care are correlated with better health outcomes.

III. Equity

The medical home principle of a regular primary care physician, based in a local, community setting, also leads to more equitable care for individuals. The increased amount of primary care physicians was significantly associated with narrowing the racial disparity among Caucasians and African Americans in specialty referrals. Moreover, for both rural and urban areas, African American users of Community Health Centers, pilot medical home projects, had a lower percentage of low-birth weight babies compared to non-users. Additionally, states with high-income inequality had a 17% decrease in post-neonatal mortality when they had primary care resources. Therefore, the emphasis of the medical home model on first-contact, comprehensive, primary care improves the health of disadvantaged groups, and creates an equity-enhancing effect.

Policy Implications:

As the Affordable Care Act has incentivized citizens to gain health insurance, there is a rising need for efforts to support the increased demand for care. A medical home, which provides a source of frontline care, community-based care, comprehensive care, longstanding physician-patient relationships and coordinated care, is exemplified to provide increased effectiveness of services. The model has shown to reduce health care costs for both the patient as well as for clinics, hospitals, and other funding sources such as the government. Moreover, the model is associated with increased patient satisfaction and better quality of care, which leads to improved health outcomes.

Therefore, with the recent increase in the demand for primary care physicians as well as the ineffectiveness of the current United States health care system, introducing policies supporting the medical home model would be extremely impactful. Similar to the ACA, a policy measure that increases access to care by establishing the medical home model clinics within local communities across the nation, analogous to online marketplaces for health insurance, would be an effective method. Another method for a policy reform, to increase access to medical home physicians, could be to ensure that each individual with health insurance also has a designated primary care physician.

Furthermore, another approach could be to require patients to attain referral by their primary care physician before they pursue any secondary, specialty services. However, this last method may face enormous backlash from specialty physicians, as it would lower their annual income based on the fee-for-service system. However, an approach that introduces this medical home concept as the foundational, frontline care within the United States health care system will allow for the intended motive of the ACA, increased access to care, to be achieved. Furthermore, the cost saving methods of the medical home model, will allow for the government to meet the current demand for primary care physicians while minimizing costs.

Links to Other Resources of Interest:

- What is a medical home? Why is it important?: http://www.hrsa.gov/healthit/toolbox/ChildrensToolbox/BuildingMedicalHome/whyyimportant.html
- The Affordable Care Act: http://www.hhs.gov/healthcare/rights/
• Are There Enough Doctors For The Newly Insured?:

• WHO Asses the World’s Health Systems:

References:

2. AAFP, AAP, ACP, and AOA. Joint Principles for Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home. February 2007. Patient Centered Primary Care Collaborative.


