Commentary

Health Disparities and the Primary Care Medical Home: Could It Be That Simple?

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For decades, advocates of comprehensive primary care have asserted the value of this apparently simple, common sense approach to health care. The presence of a longitudinal relationship with a single source of care that address the comprehensive health care needs of a child, these advocates argue, improves outcomes and enhances the family experience of care as well. Ecological analyses consistently show a strong association between the availability of systems of comprehensive primary care and improved population health.1

Yet, although the scientific data supporting this approach have gradually grown, societal trends in the American health care system moved in the opposite direction. Health care has become increasingly oriented toward specialty care, whereas primary care pediatrics has increasingly become a high-volume, low-acuity triaging process, particularly in communities where specialty services are relatively accessible. Concurrent with these trends in health delivery, health care costs have continued to grow, and relative outcomes for Americas have continued to decline compared with the rest of the developing world.2 Moreover, disparities in care as well as in outcomes have persisted in many areas and grown in others.3

While these trends were evolving and garnering attention in health services research, studies of the microenvironment of care increasingly clarified the processes of care within a practice setting that were associated with better outcomes both in the area of prevention and in the area of chronic illness management. These studies found that the core components of achieving better outcomes for both children and adults with chronic conditions as diverse as asthma, diabetes, and arthritis were effective care planning and shared goal setting that supported the ability and motivation of patients and their families to effectively manage their conditions.4,5 The studies suggested that specific ways of organizing practices—for example, through the use of care teams as well as the assis-

tance of registries of patients with specific conditions or in need of specific services—facilitated effective goal setting. And they reinforced the importance of effective communication that addressed cultural diversity and language as essential to the process of goal setting.

These two strands of research—emphasizing the importance of comprehensive primary care at a macro level and clarifying the process of care at the microlevel—came together in what the American Academy of Pediatrics long ago termed the “medical home.”6 Although long advocated by the American Academy of Pediatrics as a desirable approach for provision of care—ideally for all children but particularly for children with special health care needs—the concept was slow to spread. At a conceptual level, the distinction between the “medical home” and usual primary care has often not been well articulated. At a pragmatic level, both the alignment of financial incentives and the practical supports—training, health information technology, personnel—that would facilitate the adoption of this model were also absent or minimal.

This all changed in 2006 and 2007 when two additional trends came to bear. First, the other primary care professional societies (beyond pediatrics) recognized that the medical home model could become a rallying cry and organizing principle for their members and their efforts to reinvigorate primary care.7 Second, American industry, stirred by their real world observations of the better outcomes at lower costs achieved in other countries, rallied behind this concept.8 The grey literature—foundation and government reports—began to document cost savings associated with some medical home models, as well as the success of these models in reducing or eliminating health disparities.9 Such studies and advocacy have vaulted what was a back-room conversation to the front tier of health policy. They also have linked establishment of a medical home with significant financial incentives for practices, potentially leading to a rebalancing in earning potential of primary care and specialty oriented physicians.

It is in this rapidly evolving and highly topical policy environment that the papers in this issue on the medical home emerge, bringing highly policy-relevant information to the debate. The paper by Krugman and colleagues10 asks a simple question: do parents assess the quality of primary
The medical home does. The investigators did not assess the more complex formulation of the medical home, but used the more straightforward assessment of primary care per se. They found that parents’ experiences were quite comparable and positive between those of third-year and first-year residents, although parents reported third-year residents were more likely to discuss the child’s behavior. One potential explanation for the comparable results is that the continuity practices—perhaps through the systems established in these programs to track patients and provide care when residents are not available—are team-based sites, not dependent on the level of knowledge and experience of the individual physician per se. Whether in fact such hospital-based training sites can achieve the aims for the medical home of improving outcomes and reducing costs is a crucial policy question and outside the scope of the report by Krugman and colleagues.

Much effort has been made since the establishment of Medicaid and its expansion program, the State Children’s Health Insurance Program, to assure that all children have an identified primary care provider, on the assumption that having an identified primary care provider is a good proxy for receiving high-quality care. Although disparities in having a primary care provider per se may have diminished over the past 3 decades, disparities in outcomes—such as emergency department visits—persist. Both Stevens and colleagues and Raphael and colleagues address the question of whether disparities remain in access to a medical home, rather than simply to having an identified primary care provider. The second manuscript of Raphael and colleagues and Raphael and colleagues address the question of whether disparities remain in access to a medical home for minority and uninsured children, and these disparities exist for all children, for children with the most common chronic medical condition (asthma), and for all children with special health care needs. Raphael’s second paper also suggests that although the presence of a medical home is associated with lower rates of emergency department use for all, such programs (as measured through these surveys) do not eliminate disparities. Such information serves to set reasonable expectations for what medical homes can and cannot do.

It is also worth noting that the strength of the measurement strategy used in these papers is that they are based on the patient perspective—ultimately the most important as they reflect the experience of care. On the other hand, the measures pose a low bar for success, far less rigorous than suggested through the structural criteria of the National Committee for Quality Assurance patient-centered medical home measure or the more aspirational medical home index widely used to guide improvement programs. It is indeed promising that implementation of such comprehensive and transformational models would result in even greater reductions of disparities. The many demonstration programs now underway—unfortunately almost all in the adult world—should inform this question.

REFERENCES


