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## Idaho moves toward ‘medical home’ model of care

Medical home is a term you’ll hear more in the coming years, and it doesn’t refer to a place you might live if you need health care.

Instead, think along the lines of an Internet browser homepage — it’s designed to help you coordinate all your treatment and make it easier for you to access practitioners and specialists. Medical homes are also aimed at saving money, improving efficiency of care, and encouraging the shift toward electronic records.

“One of the biggest benefits is it will improve patients’ care because it will improve communication between health care deliverers and patients,” said Dr. Mary Barinaga, Idaho assistant clinical dean for WWAMI, the Washington, Wyoming, Alaska, Montana and Idaho medical education partnership.

“I’m very enthusiastic about the whole concept of the patient-centered medical home; it’ll allow us to deliver health care in a more efficient and cost-effective manner,” she said. “It’s really a win-win proposition for not only we health care providers, but our patients and actually the nation, because it’ll keep costs down.”

In practice, this might mean that when a patient recognizes the symptoms of, say, a urinary tract infection, she can call a nurse line or send an email to her doctor to get the needed prescriptions instead of scheduling an office appointment. This would use less of the doctor’s time, costing both the patient and the provider less money while getting the patient the treatment she needs more quickly.

How doctors would be compensated for this shift in services hasn’t been worked out, but it could be similar to how the medical home concept works for Medicaid patients under the Healthy Connections program.

Medicaid pays Healthy Connections providers a set amount per patient per month — between \$2.50 and \$3.50, depending on the patient’s needs and what services are provided — whether the doctor sees the patient that month or not.

“We would hope the per member, per month fee would be enough to offset any additional expenses they have,” said Tom Kearns, program manager for primary care with Healthy Connections in Boise. Those expenses might include longer clinic hours, a nurse phone line, or salary for a case manager.

But in return, the doctor’s time is freed up from tasks that can be done by other health care professionals, allowing for greater focus on the patients most in need.



Kearns said the medical home model has provided Medicaid patients, who traditionally have had a hard time accessing care, more choices in primary physicians and specialists. It has been so successful that Healthy Connections estimates that 90 percent of Idaho primary care providers are signed up to participate. Kearns noted that a misconception remains that participating physicians would be required to take on Medicaid patients; the providers can limit whom they see.

In addition to the statewide implementation of medical homes for Medicaid patients, there have been a few small pilot programs, including at St. Alphonsus Regional Medical Center in Boise and at safety net clinics throughout the state. These were created through the Idaho Medical Home Collaborative, an initiative launched by Gov. C.L. “Butch” Otter in 2010.

“Building partnerships. Fostering more cooperation between the public and private sectors. Doing more with less,” Otter said in his January State of the State address, referring to the Collaborative and other initiatives. “All that is part of what must be a cultural change in our policies and our programs throughout state government — a change in how we set our priorities and how we approach challenges.”

Larger medical home pilots are expected to launch this year in Idaho, with data returned in two to three years, said Neva Santos, executive director of Idaho Academy of Family Physicians, who is on the Collaborative board.

“The ... hard part is going to be demonstrating; people want to see data before they buy into something,” Barinaga said. “It’s a really huge paradigm shift.”

If the idea of a single individual coordinating care seems familiar, that’s because it echoes the “gatekeeper” concept that was part of HMOs starting in the mid-1980s. “Gatekeepers became a way to not allow patients to access a specialist or certain procedures,” said Rod Barton, administrator of Cassia Regional Medical Center.

In part, that was because the gatekeepers were part of the insurance industry and had pressure to keep costs down, often resulting in patient dissatisfaction or even significant negative outcomes for patients.

Barton said he is watching and waiting to see what results from the medical home pilots. Gatekeeping “started off as a great idea; it got twisted a bit and turned out to be not very good. We’ve been burned before and need to see how it (the medical home concept) unfolds,” he said. “I’m always aware there are unintended consequences.”

So what’s the difference between an HMO and a medical home? Under HMOs the gatekeeper was in the insurance industry. With medical homes, it’s your primary care provider, whom you pick for yourself — the idea is that the patient is at the center of all decisions.

So far, the insurance industry seems to be on board with medical homes in Idaho, with several major companies at the table as part of Otter’s Collaborative.

“For our members to be able to have a centralized location where their care can all go through is super-helpful to them,” said Josh Jordan, corporate communications specialist for Blue Cross of Idaho.

As long as a large percentage of providers are participating in the system, he said, Blue Cross doesn’t believe access to specialists will be a concern for patients. The Collaborative is also trying to figure out exactly how payment systems would work — for patients, providers and insurance companies — while other issues will be addressed as they emerge.

“It’s a relatively new concept, and relatively complex to get everyone on the same page working toward the same thing,” Jordan said. “There are several challenges, none of which are insurmountable.”

Barton said he anticipates issues might arise if patients go outside their local system — which in rural Idaho is already well coordinated, because there are comparatively few providers, who usually know each other and communicate easily.

“The problem with that is if I need to go to Salt Lake for surgery, I’m not in the Burley system any more,” Burton said, posing an example where a Cassia County heart attack patient comes to the Burley emergency room, then is flown to Utah for treatment. “Now it becomes, who do you pay, the Burley hospital because that’s where it started, or the Salt Lake hospital because that’s where the patient went? ... There’s more questions than answers right now.”

Idaho is notorious for having few doctors, both primary care and specialist, which is made more challenging by the state’s rural nature and its size.

Medical homes, Barinaga said, could ease that shortage by using nurse practitioners, physicians’ assistants, dieticians and other non-physician caregivers to supplement care. They often don’t do so now because doctors’ offices are paid when a patient visits the physician; under a medical home model the monthly fee or a similar payment structure would support those other caregivers.

“It’s going to make it easier for people to practice with more common sense rather than that face-to-face need to keep the lights on,” Barinaga said. And with that additional compensation, medical students might be more likely to choose family practice rather than one of the higher-earning specialties. It could even attract them to Idaho. “When they’re going out and looking for a practice, they’ll look for places that have this (medical home model) dialed in, because they know it’s a good model of care.”

Emergency room visits would likely decrease, because patients will have more choices — including after-hours options — about where and when to access care. They might be able to get a prescription for pneumonia on Friday night, for example, instead of ending up in the emergency room on Sunday night with a systemic infection.

Fundamentally, medical homes are aiming to get back to the best parts of that old country doctor, who made house calls and took care of all of a family’s medical needs.

“He took out your tonsils, delivered your babies, cared for your runny nose and also your heart attack. As we’ve become more specialized, that’s become the disconnect,” Barton said. “We don’t want to go back to the days when one doctor did all of that — specialists have their role — (but) the medical home would be that coordinated focal point.”