

GOV. OTTER GETS SOME GOOD MARKS ON HEALTH CARE PLANS FOR IDAHO

He's meeting four goals he set for himself, but some say they don't do enough for Idahoans who need insurance

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With President Obama and Congress concentrating on health care reform, Gov. Butch Otter says Idaho is getting the ball rolling right here, right now.

An opinion piece Otter wrote this month lists four steps the state has taken to improve Idaho health care. The steps were recommended in 2008 by Otter's Select Committee on Health Care. The four are expanding use of medical records, expanding use of "medical homes," adding more eligible children to Medicaid, and expanding residencies for physicians in training.

"We are making great progress on all those fronts," the governor wrote.

Independent medical experts agree. "Those are good things," said Dr. Robert Vestal, co-chairman of the steering committee of Idaho Health Care for All. His group supports a version of Medicare for everybody, an idea Otter opposes.

But Otter's four items are fewer than half of the recommendations his committee made.

Perhaps the biggest of those was a call to provide affordable health insurance for the 200,000 or more Idaho adults who lack insurance. The committee recommended adding more adults to the Medicaid program, which now covers almost exclusively children, pregnant women and the disabled. The recommendation also included a call for new, affordable insurance that emphasizes wellness and preventive care and targets people 25 to 40 years old.

The remaining four recommendations not listed by Otter were: --Expanding access to medical education.

--Establishing a council to tackle a shortage of workers in health professions.

--Expanding wellness and prevention programs, including more child immunizations and an end to sweets in school vending machines.

--Strengthening insurance, treatment for mental health problems.

These recommendations came from a panel of experts who reviewed and distilled an even bigger list of ideas generated during Otter's 2007 Healthcare Summit.

Otter says Idaho's work includes "controlling costs and improving access through a market-driven focus on preventive care, health promotion, building public-private partnerships, and application of technology and professional development." The money turning Otter's words into actions comes from private and public sources -- including the federal government.

Vestal said Otter's plan "doesn't go far enough to address the serious root problems of people who can't afford and don't have health insurance." Here are Otter's four mile markers, and how experts say Idaho is doing.

1. EXPANDING THE USE OF ELECTRONIC MEDICAL RECORDS Progress: Steady Doctors who have access to patients' treatment notes, medication histories, and lab and test results from other providers are in a better position to deliver good care than doctors who must thumb through incomplete file folders with sometimes-illegible notes.

The Legislature in 2006 established the Idaho Health Data Exchange to come up with a plan for expanding use of electronic medical records. What was needed was a system that would allow patients' medical records to travel seamlessly back and forth among hospitals, medical clinics, labs and more, said LaDonna Larson, executive director of the exchange.

The exchange mainly supports itself with fees from providers and with federal funds. So far, the exchange links three hospitals, including Saint Alphonsus and St. Luke's hospitals in Boise, with three laboratories and a growing number of physicians' practices. This week, the exchange received \$5.9 million in federal economic-stimulus money to continue connecting the dots.

Dr. Julie Foote, a Boise endocrinologist, says she is part of an ambitious pilot project being developed that -- among other things -- lets her send prescriptions directly to pharmacies by e-mail from a secure Web site.

She also can access information on patients' prescriptions from other doctors. That helps keep her from prescribing medicines that could be dangerous if they are combined with prescriptions patients already are taking. That is a big help: Many people don't remember doses or even the names of the pills they take.

2. EXPANDING THE USE OF MEDICAL HOMES Progress: Steady The "patient-centered medical home" is a doctor who will coordinate all of your care and help you make treatment decisions. It means you have a primary-care doctor -- a category that includes internal and family physicians -- who can access your electronic medical information from multiple providers by using a secure Web site that protects patients' privacy.

"Right now, we don't have common roads for different systems to communicate with each other," said Dr. Ted Epperly, a Boise family doctor who is chairman of the board of the American Academy of Family Physicians.

A roadblock is money. Primary care doctors don't get paid for time they spend checking patients' histories, conversing with patients via the Internet or phone, or for most any other patient contact that is not face to face, he said.

A pilot program started in Idaho this past summer will help doctors, insurers and others in the health care industry figure out how to pay primary-care doctors for turning their offices into medical homes. For example, doctors might get a financial reward because 93 percent of their diabetes patients are meeting goals aimed at managing their disease.

The funding for this pilot project so far is coming from the private, nonprofit Commonwealth Fund. The goal is to have insurers and other industry players help pay for medical-home reimbursement.

3. EXPAND THE NUMBER OF CHILDREN ON MEDICAID Progress: Rapid -- but not just from state efforts

The sizable expansion results largely from the recession, which increased joblessness and a loss of insurance provided by employers, and from a boost in funding from the federal government to help families suffering job loss.

The governor's goal is to cover children who are eligible for Medicaid health coverage but aren't getting it. Early in Otter's term, Idaho was poised to implement a variety of strategies to cover about 27,000 children who could be getting Medicaid health coverage but weren't. The state Department of Health and Welfare started making changes aimed at boosting the number of children who have coverage.

But the economy soured, forcing the state in late 2008 to stop spending money to encourage signups. More children joined anyway as parents lost jobs and family incomes dropped.

One of the Health and Welfare changes was to rename the program from Medicaid to something that didn't sound like a program for the poor. Many parents weren't applying because they didn't consider themselves poor enough to qualify. The new name is Idaho Health Plan Coverage for Children.

Another change that was recommended, but not put into place, was to give parents information about the children's health plan when families apply for free or reduced lunches at school.

Idaho had 136,649 children receiving Medicaid in December 2008. Of those, 25,021 were enrolled in the Children's Health Insurance Program, or CHIP, a Medicaid program that covers children whose families make too much money to qualify for regular Medicaid. By December 2009, 153,761 children were enrolled in Medicaid, including 27,852 in CHIP.

4. MORE EDUCATIONAL OPPORTUNITIES FOR DOCTORS Progress: Steady There's a lot of research to back up the notion that doctors tend to practice in the regions where they do their residency -- the extra training beyond medical school that trains physicians in their chosen fields.

Idaho has a residency program for family-medicine doctors that has graduated 230 doctors in 35 years, more than half of whom remained in Idaho to practice, Epperly said.

The residency's class size in Boise has increased from eight in 2001 to 13 now. In Pocatello, the number has risen from five to six.

Idaho also needs more specialized residency programs for specialists like surgeons, obstetricians and gynecologists and pediatricians, Epperly said. And there are plans to start a residency in internal medicine in 2011.

State officials and the private sector worked together to start a small residency for psychiatrists in a state with a serious shortage and a high suicide rate. That residency so far has two graduates, both of whom are staying in Idaho, Epperly said.

While the overall numbers are small, the progress is steady because the residency has not lost funding this year, and the psychiatric residency is set to receive a small financial boost -- about \$70,000.