

Idaho Safety Net Medical Home Initiative

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Purpose of the Idaho Safety Net Medical Home Initiative

- In 2008 IPCA received a 4 year grant to develop the Medical Home model in 13 safety net clinics in Idaho
- Safety net clinics are those serving primarily low income, underserved populations
- The Medical Home is intended to improve patient care and patient outcomes, and reduce costs of care

Why Idaho?

- Idaho offers:
 - Small population, relatively simple payer industry
 - Opportunity to explore how the PCMH can evolve in safety net settings, rural and frontier settings
 - Governor's Medical Home Collaborative, Health Care Council recognize importance of medical home model in providing needed care, reducing costs

Vision/Goals For The Initiative

- Participating clinics serve as a model for transformation to PCMH.
- Spread PCMH model to other safety net providers and to private practice physicians in Idaho.
- Work with stakeholders to redesign health care reimbursement system to support the added value of the PCMH.

Vision for Medical Home Clinics in the Future

- All patients will have a continuous relationship with a personal clinician and care team that coordinates care for both wellness and illness in a culturally competent manner.
- Episodic patient care will be replaced with coordinated and comprehensive care and a long-term healing relationship.
- Health outcomes for patients with chronic conditions will improve significantly
- Patient, clinician and staff satisfaction will improve



Vision for Medical Home Clinics in the Future

- Operational changes within each clinic will include:
 - Enhanced access and communication for patients.
 - Use of patient tracking and registry functions using HIT.
 - Improved patient self-management support.
 - Systematic test and referral tracking.
 - Performance reporting and improvement at all levels of the organization.
 - Organization-wide use of evidence-based decision support.
 - Improved use of community-based resources.



How does the Patient-Centered Medical Home look different from what we do today?

Today's Care	PCMH Care
My patients are those who make appointments to see me.	Our patients are those who are registered in our medical home.
Care is determined by today's problem and time available today.	Care is determined by a proactive plan to meet health needs, with or without visits.
Care varies by scheduled time and memory or skill of the provider.	Care is standardized according to evidence-based guidelines .
I know I deliver high quality care because I'm well trained.	We measure our quality and make rapid changes to improve it.
Patients are responsible for coordinating their own care.	A prepared team of professionals coordinates all patients' care.
It's up to the patient to tell us what happened to them.	We track tests and consultations, and follow up after ED and hospital visits.
Clinic operations center on meeting the doctor's needs.	An interdisciplinary team works at the top of our licenses to serve patients.

From the presentation "Patient-Centered Medical Home for Idaho" by Paul Grundy, MD, MPH, IBM Global Business Services, June 28, 2009.



How does Medical Home transformation support the state vision for the health care system?

- Increased resources focused on primary care and prevention result in improved individual patient health outcomes and population based outcomes
- Integrated, coordinated care results in reduced duplication of services, reduced overall health care costs
- Agreed upon PCMH definition, recognition standards improve Idaho's ability to attract primary care providers, and investment in primary care service systems (pilots, grant opportunities)
- Promotes patient responsibility for self-care

What is the Timeline for Clinic Transformation to Medical Home in Idaho?

- This will be a transformative effort playing out over the next several years as public and private clinics move to the medical home model:
 - Our goal is to have all clinics that are participating in the SNMHI recognized as NCQA by 2012
 - Our goal is to have all other Idaho CHCs recognized as NCQA by 2013
 - The Idaho Medical Home Collaborative is developing a pilot for private primary care clinics to transform over the next 2 years.
 - The new health care law provide incentives for practices to evolve to the Medical Home model



Barriers/Challenges

- Funding to make significant changes to practice sites, especially up-front investments in electronic health records and other IT systems
- Resources for clinician and staff training in medical home model
- HIT development to provide patient data in clinic and share with other providers
- Reform primary care reimbursement from traditional fee for service to care coordination fee, preventive health emphasis, shared savings

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