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Guest Commentary: Opportunities in the Medical Home

The medical home healthcare model is going mainstream. Commercial health plans and employer groups are continuing to show interest in the potential value of the medical home approach.

Driving some of the interest is the increasing prevalence and associated costs of chronic conditions in the United States coupled with the growing shortage of primary care clinicians. Primary care providers, health plans, and disease management companies all focus benefits and services on improving health outcomes while trying to contain the cost of care provided.

Since all these players ultimately appear to have common goals, the medical home model seems like a natural progression toward effective care collaboration. As this care model has continued to progress from the government to the commercial space, some of these organizations fear that the need for their services, especially in the areas of case management, disease management, health coaching, and wellness activities, will diminish rather than flourish. Realistically, there will be a continued place for them in the medical home.

While the primary care provider is the captain of the medical home ship, in many cases they don't have the resources, expertise, or capital to hire those necessary to provide complex care. In order to fill this void, they will need to partner with health plans, and case management and disease management companies to provide these types of services.

Rather than feeling competition from primary care providers, health plans should be interested in attracting and retaining providers with the necessary desire and skills to coordinate care for patients across the healthcare continuum. Adding primary providers increases the number of potential office visits, resulting in more revenue for the health plan and decreased overall healthcare expenditures.

Bringing together the efforts of a multi-disciplinary team further reduces cost of care through avoiding duplication of efforts and more effective use of resources. Ideally, a multidisciplinary team works closely with the primary provider taking collective responsibility for the ongoing care of the individual while sharing complex sets of tasks.

Care coordinators, and case and disease managers working with the primary provider can partner with the patient to act as advocates for their patients, supporting optimal, patient-centered outcomes. The synergy of primary providers, health plans, and disease management

organizations working together with shared care plans, driven by evidence-based interventions, offers the opportunity for organizations to redefine how programs integrate while monitoring and managing at-risk members.

Concern has arisen as specialty providers, such as case and disease managers, have felt that their services could be replaced by the medical home model. Yet it is estimated that in our current healthcare system, the average primary care physician only spends about an hour with a patient per year. That is not an adequate amount of time to treat illnesses, provide proper preventative care, assess for social and educational needs, identify and implement interventions, as well as educate the patient.

This offers a great opportunity for primary care providers to team with existing health plan and care management staff to create efficiencies that should lower the cost of care for most patients while affording physicians more time to provide the quality care their patients and payers deserve.

A critical, yet costly component in the medical home model is the adoption of technology, such as electronic health records. While potentially out of reach for the average provider, partnering with health plans or care management organizations that have existing technology infrastructures opens additional options, such as cost sharing, putting this option within reach of the provider.

The tracking of performance measures for quality reporting becomes more accurate and efficient when system-driven analysis is possible. Prospective data collection becomes a reality providing the primary care physician with essentially real-time quality measures for the purpose of benchmarking and improvement. Information technology, such as Web portals, offers new and innovative ways for care providers to communicate with their members.

While the shift in focus toward medical home models in commercial populations holds promise for improved quality of care and cost savings, it is not without significant obstacles for adoption. Without payment systems that appropriately recognize the added value provided by the medical home healthcare model and technology systems to support communication and coordination between entities, the real potential of a medical home will not be realized.

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